Allergy, Asthma, Rheumatology
ASSOCIATES, PC

5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 FAX: 315-478-0439

www.aaracny.com

MICHAEL G. SHEEHAN, M.D. HARCHARAN SINGH, M.D.
Certified by the American Board of Allergy and Immunology

Welcome to our practice!

It is our pleasure to serve you! AARA is a subspecialty practice dedicated to the treatment of allergic and immune related diseases in the CNY area. You can find more about us on our website, **www.aaracny.com**

Name of Patient: _____ Date of Birth: _____

Appointment with: **Dr. Michael Sheehan** Appt. Date &Time: _____

NEW PATIENT APPOINTMENT CHECKLIST

1. **PLEASE** bring your insurance card, photo ID, and COVID vaccination card (if applicable). If a referral is required, make sure it is in place prior to your appointment. Bring Cash, Check, or Credit Card for co-payment, deductible, and/or co-insurance.
2. **PAYMENT IS EXPECTED AT DATE OF APPOINTMENT**. Estimated amount $_____ Additional charges may apply for breathing tests and/or allergy testing, if done.
3. Please bring copies of any labs done at another physician's office, for review.
4. We **CANNOT** promise testing will be done on the first visit.
5. Please do not bring children to your appointment unless the child is the patient.
6. Bring a list of ALL medications and include name, strength, and dosage.

GENERAL INFORMATION

- HOURS 8 AM – 5 PM: Monday, Tuesday, Thursday, Friday.
- CLOSED FOR LUNCH: 12 PM – 1 PM
- Closed Wednesday, with some holiday exceptions.
- INJECTION CLINIC: Open Monday, Tuesday, Thursday from 8 AM – 4 PM (by appointment only).
- AARA physicians are available after hours, for emergency calls ONLY. Please call (315) 478-2339 for the beeper #.
- Any patient under 18 years of age **must** be accompanied by a Parent/Guardian. If a parent cannot be present, the parent needs to comply with office policy and complete "Designation to Permit Another Person to Consent for Health Care" form. Form is available on our website, or upon request.
- We ask that you notify us of any prescription refills you need at the time of your visit.
- Please allow 3 business days to process prescriptions.
- Please allow 10 business days to copy or transfer records (fee per page charged).
- Patients who do not keep appointments, will be asked to reschedule appointment before a prescription is refilled.
- A patient not seen within 6 months may be asked to schedule an appointment before any forms, including school forms, are processed.

INITIAL PLEASE _____

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AARA's FINANCIAL POLICY:

- Any co-pay, deductible, co-insurance, and past due balances are due at the time of service. If you have not met your deductible, payment in full is due at the time of service.
- It is always the patient's responsibility to make sure necessary authorizations are in place and insurance information is up to date! If it is not, or we cannot verify such information, we reserve the right to cancel/reschedule the appointment, or you may be held responsible for payment.
- Patients with balances may be asked to reschedule non-urgent visits until payment has been made.
- We ask for the courtesy of 24-hour notice to cancel a scheduled appointment. We reserve the right to charge a "NO SHOW" fee for patients who fail to give 24-hour notice. This charge is not covered by insurance.
- We participate in the following insurance plans: AARP, AARP Medicare Complete, Aetna, Excellus BCBS, CDPHP, CHAMPVA, Emblem Health, Fidelis, Humana, Independent Health (PPO), Indian Health Services, Lifetime Benefit Solutions, Martin's Point (with authorization only), MultiPlan (PHCS), MVP, National Gov't Services (Medicare), The Empire Plan, Tricare East (Prime needs authorization), Tricare For Life, UMR, UnitedHealthcare (except Medicaid & Oxford; Harvard Pilgrim depends on contract), Univera, VA (with authorization only), WellCare (Today's Options) PPO, PFFS, HMO, WellMed, as well as, some smaller plans.
- If you do not see your insurance plan listed above, please contact us to inquire about our participation. **This listing may change without notice**. Please note that our relationship is with you and not with your insurance company.
- We **do not** participate with Medicaid FFS (Fee For Service) as a primary, or secondary, insurance. Unfortunately, we will not be able to accept you as a patient.
- Allergy, Asthma, Rheumatology Associates reserves the right to discontinue our professional relationship with you if our policies are not adhered to.

I have reviewed and understand Allergy, Asthma, Rheumatology Associates' Office Policies.

Print Patient Name: _____ Date: _____

Signature of Patient (or Guardian if Patient is a minor): _____

Print Guardian Name (if applicable): _____

Relationship (to Patient): _____

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PATIENT CONSENT FORM

Please list the family members, or other persons, with whom we may inform about your general medical condition and discuss your medical condition in an emergency situation, including diagnosis, treatment and other health care information including payment. **(It is not necessary to list your primary care and/or referral physician(s).)**

Print Name: _____ Print Name: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

I _____ hereby authorize Allergy, Asthma, Rheumatology Associates (AARA) to release all information necessary to complete insurance forms and to secure payment. I also authorize payment for all surgical/medical services to be sent directly to AARA. I accept responsibility for all medical charges not covered by insurance. **INITIAL** _____

I agree to pay any co-pay, coinsurance, deductible and/or balance at the time of services unless other arrangements have been made in advance. **INITIAL** _____

Correspondence regarding medical charges will be sent to the address of the insurance holder unless other arrangements have been approved in advance. I assume responsibility for all reasonable collection costs, including attorney's fees.

I authorize AARA to send correspondence to the address I have placed on record and to leave messages on my telephone answering machine/voice mail pertaining to appointment, payment issues, test results or other personal care information unless I have provided alternative contact information in advance.

I understand and acknowledge that members of AARA, as well as its employees will have access to my/the patient's medical information as reasonable necessary to carry out continuity of care, treatment plans and recommendations, payment activities and health care operations (including, but not limited to, quality assurance activities and audits). I consent to the release of any medical information about me (and any other individuals for whom I can give consent) to my health plan and any health care providers involved in caring for me, or to such individuals as reasonably necessary for my health plan or my providers to carry out treatment, payment or health care operations.

Print Patient Name: _____ Date: _____

Signature of Patient (or Guardian if Patient is a minor): _____

Print Guardian Name (if applicable): _____

Relationship (to Patient): _____

Telemedicine (Videoconferencing) Consent

1. I authorize Allergy, Asthma, Rheumatology Associates, PC to allow me[1] to participate in a telemedicine (videoconferencing) service with **Dr. Michael Sheehan** **or** **Dr. Harcharan Singh**
2. The type of service to be provided by via telemedicine is: **Evaluation and management**
3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I will not be in the same room as the healthcare provider performing the service. I understand that there are parts of my treatment and examination which cannot be accomplished because this is not a face-to-face meeting.
4. The nature and purpose of the videoconferencing technology have been fully explained to me. I have also been informed of expected risks, benefits and complications (from known and unknown causes), discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician face-to-face. The risks of not using telemedicine sessions have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my healthcare provider or I can discontinue the telemedicine service, if we believe that the videoconferencing connections are not adequate for the situation.
6. I agree to permit my healthcare information to be shared with other individuals for the purpose of scheduling and billing.
7. I acknowledge that I have the right to request the following:
   a. Omission of specific details of my medical history/physical examination that are personally sensitive, or
   b. Termination of the service at any time.
8. It is the responsibility of the telemedicine provider to conclude the service upon termination of the videoconference connection.
9. I understand that I will be billed by my telemedicine healthcare provider.
10. My consent to participate in this telemedicine service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
11. No guarantees or assurances have been made about the results of this service.
12. I confirm that I have read and fully understand the above information. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

*SIGNATURE of Patient/Relative/Guardian	Print Name
Relationship to Patient	Date/Time
Witness	Date/Time
Interpreter (if required)	Date/Time

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed telemedicine session, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physician's Signature	Date/Time

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.

[1] The words "I", "me" "my" and "you" refer to the patient or the individual who has legal authority to act and consent for the patient.

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PATIENT INFORMATION FORM

NAME: (FIRST)_____ (MI)_____ (LAST)_____

DOB: _____ AGE: _____ GENDER: M F IDENTIFY: _____

NAME (FOR MINOR): (MOTHER): _____ (FATHER): _____

ADDRESS: STREET _____

CITY: _____ STATE: _____ ZIP: _____

PHONE HOME: _____ WORK: _____ CELL: _____

EMAIL: _____ SS #: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

REFERRING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

RESPONSIBLE PARTY: CHECK IF SAME AS ABOVE _____

NAME: (FIRST)_____ (MI)_____ (LAST)_____

RELATION TO PATIENT: _____

ADDRESS: STREET _____

CITY: _____ STATE: _____ ZIP: _____

PHONE HOME: _____ WORK: _____ CELL: _____

EMPLOYER: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY

COMPANY: _____

ADDRESS: _____

ID#: _____

GROUP#: _____

POLICY HOLDER NAME: _____

DOB: _____

SECONDARY

COMPANY: _____

ADDRESS: _____

ID#: _____

GROUP#: _____

POLICY HOLDER NAME: _____

DOB: _____

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NAME: DATE: AGE: DATE OF BIRTH:
CHART#:

STATEMENT OF CURRENT PROBLEM

PAST MEDICAL HISTORY
1. ILLNESSES:

ALLERGY TO MEDICATIONS:

ALLERGIES TO FOOD:

CURRENT MEDICATIONS

HOSPITALIZATIONS/SURGERIES:

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FAMILY HISTORY:

CHART#_____

DO YOU SMOKE? Y N

PACKS/DAY? _____ # YEARS_____

REVIEW OF SYSTEMS(circle all that apply)

SKIN	CARDIO	PULMONARY	GI	GU	MS	NEURO	CT
ıing	Chest pain	Cough	Difficult to	Pain on	Joint pain	Headache	Dry Eyes
		Wheezing	Swallow	Urinating	Limited Movement	Double Vision	
Swelling	Palpitations		Heartburn	Kidney Pain	Joint swelling	Blurry vision	Oral Ulcers
Red Rash	Swollen Ankles	Short of Breathe	Nausea	Blood in Urine	Morning Stiffness	Light hurts eyes	Tongue swell
Dry/Flaky	Fainting		Vomiting				Facial Swelling
Burning	Sev.Dizziness	Pain on Breathing	Acid taste in mouth	Testicular Pain		Ringing in Ears	Neck Pain
Blisters			Diarrhea	Vaginal Discharge		Hearing Loss	Back Pain
Ulcers	Dizzy when standing	Chest Tightness	Constipation		Muscle Pain Weakness		Hand Pain in cold weather

ENT:

Congestion Sneezing Itching Runny Nose Post Nasal Drip Ear Pain/Illness

CONSTITUTIONAL:

Fever Chills Malaise Weight Loss Eye Itching Anorexia Bulimia

HOME ENVIRONMENT: Basement: Damp? Yes No

Age of Home:_____ How Heated?

Location (Circle one):

A/C? Yes No

Rural Central Air? Yes No

Urban Portable? Yes No

Suburban What room? _____

Pets in the House? Yes No Dog(s)_____

Cat(s) _____

Other_____

SMOKERS in the House: Yes No

Dehumidifier? Yes No

Pillow: Feathers Cotton

Comforter: Feathers Cotton

Air Purifiers? Yes No

Central Air? Yes No

Portable? Yes No

What room?_____

How often is Bedlinen washed: 1x/week

2x/month

1x/month

Do you wash in: HOT WARM COLD

Bedroom Floor:

Carpet? Yes No

Hardwood? Yes No

Area rug? Yes No

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From the North:

Take I-81 South toward Syracuse
Take exit #29S onto I-481 South toward Dewitt
Take exit #4 onto I-690 West toward Syracuse
Take exit #17/Bridge Street
Turn right on Bridge Street
Turn left on Widewaters Parkway

From the South:

Take I-81 North
Take exit #16A onto I-481 North toward Dewitt
Take exit #3W and merge onto Route 5 West/Route 92 West/East Genesee Street toward Dewitt
Turn right to follow Route 5 West/Erie Blvd. East
Turn right on Kinne Road
Turn left on Widewaters Parkway

From the West:

Take I-90 East
Take exit #39 onto I-690 East toward Syracuse
Take exit #16-17/Route 635
Turn right on Bridge Street
Turn left on Widewaters Parkway

From the East:

Take I-90 West toward Buffalo
Take exit #34A onto I-481 South toward Syracuse
Take exit #4 onto I-690 West toward Syracuse
Take exit #17/Bridge Street
Turn right on Bridge Street
Turn left on Widewaters Parkway