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. Harcharan Singh** 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): _____

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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: _____

Telemedicine (Videoconferencing) Consent

1. I authorize Allergy, Asthma, Rheumatology Associates, PC to allow me[1] to participate in a telemedicine (videoconferencing) service with Dr. Harcharan Singh
2. The type of service to be provided by via telemedicine is: Consult
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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HARCHARAN SINGH, M.D.

Name: _____

For children: how is the accompanying adult(s) related to child? _____

Date of birth: _____ **Age:** _____ **Gender:** _____

Referring Doctor's name: _____

Reason for visit: _____

_____

_____

_____

Please circle any applicable symptoms (chronic or recurrent):

runny nose	sneezing	itchy nose	stuffy nose	reduced smell/taste
sinus pain/pressure	throat clearing	post-nasal drip	snoring	sleep apnea
plugged ears	itchy ears	sore throat	hoarseness	
cough	wheezing	shortness of breath	chest tightness	
itchy eyes	redness of eyes	watering of eyes	allergic shiners	
eczema	hives	angioedema		
food allergies	bee sting allergy			
heartburn	regurgitation	acid taste in mouth	vomiting	
headache	seizures	pallor	enlarged glands	
palpitation	chest pain			
arthritis	Raynaud's	Fever	Weight loss	

Current medications: Please list names of medication, dose and how long taken.

_____

_____

_____

_____

Previous allergy/asthma treatment: _____

_____

_____

_____

Medication allergies: Please list any medication allergies. _____

_____

_____

Past medical history:

Please list any previous illnesses /injuries/surgeries: _____

_____

Previous allergy testing/allergy shots? _____

_____

Family history or allergies (please circle all that apply):

Asthma	Hay fever/Sinus allergies	Nasal Polyps	Food allergies
Insect sting allergies	Hives/angioedema	Eczema	Immunodeficiency
Anaphylaxis			

Social history:

Occupation (for children- school grade): _____

Missed school/work? Yes No How much? _____

Do you smoke now or in the past? _____

How many years? _____ How many packs/day? _____

Any second-hand cigarette smoke exposure? _____

Hobbies: _____

_____

Please list any pets at home: _____

_____

How old is your house? _____

Stuffed toys?	Yes	No
Air Conditioning?	Yes	No
Heat (please circle):	Forced	Electric
Rooms (please circle):	Carpeted	Hardwood
Basement (please circle):	Damp	Dry

Questions about Nasal/sinus/ear/throat symptoms:

Severity of nasal/sinus symptoms (please circle): Mild Moderate Severe

Seasonal pattern (please circle): Spring Summer Fall Winter

What makes symptoms worse? _____

_____

How many sinus infections in the past year? _____ Ear infection(s)? _____

Questions about Chest symptoms (cough, wheezing, congestion, breathing difficulty, etc.):

How long have you had chest symptoms? _____

What triggers these symptoms (please circle all that apply)?

Respiratory infections Spring Fall Winter Dust Mold Pets

Cold weather Air conditioning Cigarette smoke

Other triggers: _____

Daytime symptom frequency? _____

Nighttime symptom frequency? _____

How often do you use rescue inhaler (puffer): _____

What treatment(s) have you tried? _____

How many ER/Urgent doctor visits for asthma in the past 12 months? _____

Ever hospitalized or admitted to intensive care unit for asthma? Yes No

History of recurrent bronchitis/croup/asthma/reactive airway disease/pneumonia? Yes No

Do you have prolonged chest congestion following a head cold? Yes No

Do you have exercise-induced cough, wheezing or shortness of breath? Yes No

Questions about Eczema:

At what age did eczema start? _____

Location(s) (please circle): scalp face abdomen back arms legs

Triggers:

Seasons (please circle all that apply): Spring Summer Fall Winter

Foods: _____

Skin care products: _____

Others: _____

Questions about Hives:

How long has the patient had hives? _____

Location (please circle all that apply): scalp face neck chest abdomen back arms legs

Itching (circle): mild moderate severe

Is itching worse at night? Yes No

Does the rash (hives) come and go, keep moving, or persist in one spot for more than 24 hours? Yes No

Any burning/pain or bruising at the site of the rash (hives)? Yes No

Lip swelling, tongue swelling, throat swelling, breathing problems associated with hives? Yes No

Triggers for Hives (please circle all that apply):

Soap Shampoo Woolen Clothing Cosmetics Detergents Conditioners

Heat Exercise Sweating Cold Exposure Sun Vibration

Pressure areas (belt line, bra line, tight socks…)

Medication: aspirin, Motrin, Aleve, and other pain relievers of the NSAID family? Yes No

Foods: _____

Other: _____

Questions about Bee Sting Allergy:

When did the reaction(s) occur? _____

Describe the setting: _____

Describe the reaction (to include location, size & symptoms): _____

_____

_____

Symptoms (please circle all that apply):

Local Swelling Generalized Hives Eyelid swelling Lip and tongue swelling Throat swelling

Breathing problems Dizziness Loss of consciousness

Other: _____

_____

Food: Describe food allergy reactions or suspected reactions. _____

_____

_____

_____

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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