Arthur M. Lubitz, M.D., P.C., F.A.A.A.A.I.
DIPLOMATE, ALLERGY AND IMMUNOLOGY

Ama Alexis, M.D., F.A.A.P.
DIPLOMATE, ALLERGY AND IMMUNOLOGY

Patient Information

Name: _____ **D.O.B:**___/___/____

Address: _____ **Apt. #:**_____**City:** _____

State: _____ **Zip:** _____ **Sex:** □M □F **Marital Status:** □M □S □D □W □O

Mobile#: (_____) _____-_____ **Home# :**(_____) _____-_____ **Work#:** (____) _____-_____

Currently employed? □**Yes** □**No** □**other** _____

Email: _____

Physician Name or Referring: _____ **Address:** _____

State: _____ **City:** _____ **Zip:**_____ **Phone:**(_____)_____-_____

Insurance Information

Insurance Name: _____ **Policy #:**_____**Policy Holder:** _____

D.O.B:___/_____/_____ **Relationship to Patient:** _____ **Employer:** _____

Secondary Insurance: □**Yes** □**No** **Insurance Name:** _____

Policy#:_____**Policy Holder Name:**_____ **D.O.B:**___/___/___

Pharmacy Info: Name: _____ **Phone# :**(_____) _____-_____

Address: _____

I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional costs. I authorize direct payment of covered benefits to the provider of services. The patient is responsible for all fees, regardless of insurance coverage. Payment for office visits is expected at the time of service. Credit cards may be used.

Signature: _____ **Date:** _____/_____/_____

Name: _____ **Age:**___ **Sex:** M/F

Why are you seeing us? (Please Describe)

_____

_____

_____

_____

_____

Circle if you have any of the following?

Snoring / Coughing / frequent sneezing

Asthma / Bee sting reactions / Rashes / Eczema

Itchy or watery eyes / Wheezing/shortness of

Breath/nasal congestion/ Runny nose/ sinus

Infection / bronchitis / Yellow or green nasal

Drainage/ reaction to Food or drugs

Symptoms occur most often:

□Spring□Summer

□Autumn □Winter□ Year around

Symptoms worsen/change with:

□Aerosol Sprays □ Cold air □ Plants

□ Cigarette Smoke □ Cosmetics □ pets

□ Cleaning □ Chemicals □ Fresh cut grass

□ Colds/flu □ Fragrances □ Hot weather

List your current medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Immunization Status: Are your vaccines up-to-date? □ Yes □ No

Do you have reactions to?

□Aspirin □latex rubber □insect stings

□Sulfites □food/additives □plants

□Medications □vaccines □other_____

□Soaps/fabrics softeners/cosmetics

Tell us about your environment:

Any health conditions:_____

Home	Pets	Flooring	Pest
□House	□None	□Wood	□Mice
□Apt	□Cats	□Carpet	□roaches
□Basement	□Dog	□Rug	□____
	□____	□____	

Mold	Feather	Heating/AC
□Basement	□Pillows	□Hot Air
□Bathroom	□Comforter	□Radiant
□None	□None	□Central
□_____		

Social History:

Occupation: _____
Work exposure:_____
Skin sensitivities:_____
Alcohol usage:_____
Drug usage:_____
Tobacco History:_____

Family History:
Allergies or any other health conditions

Parents:_____
_____

Siblings:_____
_____

Other: _____
_____

Dr. ARTHUR LUBITZ, *Allergist*
Dr. AMA ALEXIS, *Allergist*
DANA SERLING, *PA-C*

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name (*Patient or Representative*)

_____ _____/_____/_____

Signature Date

Relationship to Patient (*If other than Patient*): _____

Witness: _____

Printed Name (*Practice Representative*)

_____ _____/_____/_____

Signature Date

nycallergydoctor.com Tel: (212) 247-7447.....Fax: (212) 307-0865 315 West 57th, St. Suite 309, New York, NY 10019

Dr. ARTHUR LUBITZ, *Allergist*
Dr. AMA ALEXIS, *Allergist*
DANA SERLING, *PA-C*

Our Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our financial fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

If you provide our office with the necessary information regarding your insurance plan, we will submit our claim directly to your carrier. **YOU ARE RESPONSIBLE TO PAY THE APPROPRIATE CO-PAYS, DEDUCTIBLE AND/OR CO-INSURANCE.** We accept cash, personal checks and VISA/MASTERCARD.

REGARDING INSURANCE:

If your plan requires authorization from primary physician, it is your responsibility to obtain the written referral or authorization number prior to your visit with the doctor. If you arrive at our office without prior authorization, full payment will be expected at time of service and refunded to you when authorization is obtained.

Insurance is a contract between you and your insurance company. In most cases, we are **NOT** party to this contract. We file insurance claims as a courtesy to our patients. We will **NOT** become involved in disputes between you and your insurance company regarding deductibles, co-insurance, co-payments, referrals, "usual & customary charges", etc., other than to supply factual information as necessary. If you have not paid the doctor and your insurance company inadvertently pays you directly, you must send this payment immediately to the doctor. You are responsible for the timely payment of your account including all non-covered services.

MEDICARE PATIENTS:

You are responsible for a yearly deductible of $140 and the 20% portion not paid my Medicare. If you have supplemental coverage, we will submit the claims for you. If you are enrolled in a Medicare HMO (Hip, Oxford, US Healthcare, etc), it is your responsibility to inform our staff. If the appropriate referrals are not obtained full payment will be respected at time of service.

_____ _____/_____/_____

RESPONSIBLE PARTY SIGNATURE **DATE**

nycallergydoctor.com Tel: (212) 247-7447.....Fax: (212) 307-0865 315 West 57th, St. Suite 309, New York, NY 10019

ARTHUR M. LUBITZ, MD, PC
315 West 57th St.
Suite 309
New York, NY 10019

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

Patient MRN/Patient ID:

Please Fax signed consents to: 917-829-2096

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please ☑ Check

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

PRINT Name of Patient

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

Arthur M. Lubitz, M.D., P.C., FAAAAI
DIPLOMATE, ALLERGY AND IMMUNOLOGY

Ama Alexis, M.D.,FAAP
DIPLOMATE, ALLERGY AND IMMUNOLOGY

Dana Serling, PA-C

ALLERGY AND ASTHMA
315 WEST 57TH STREET
SUITE 309
NEW YORK, NEW YORK 10019
TEL: (212) 247-7447 FAX (212) 307-0865
WWW.MDALLERGY.COM

NETWORK AND HOSPITAL AFFILIATIONS

Dr. Arthur Lubitz, Dr. Ama Alexis and Dana Serling, PA-C are participating physicians with the following care plans:

Aetna – Aetna Students Plan – Affinity Medicaid CHPS – Affinity Medicare Advantage - Affinity HIX - Allied Benefits System Inc. – AARP - Blue Cross and Blue Shield – Blue Card- Blue Federal – Careington (PHCS) - Carpenters Welfare Fund - Cigna – Cigna International - Consolidated Health Plan – Core Source – Coventry Health care - Empire Plan - Fidelis Medicaid – Fidelis HIX- First United American Life GHI Emblem Health - Global Care Inc. - Great West Healthcare – Harvard Pilgrim Healthcare – Health Republic – Health partners - HIP - Health First Medicaid - Health First 65 - Health First HIX- Health Plus – Magnacare – Metroplus – Medicare – Meritain Health – Montefiore CMO – Multiplan - Nippon Life Benefits – Oscar – Oxford HMO/PPO - Pointers Cleaners Welfare - Pomco Multiplan – Qualcare – Select Benefits Administrators - Travel Care Services - Travel Guard - Tricare for Life - United Healthcare - United Healthcare Community – United Healthcare Medicare Complete - UMR Insurance - 1199 National Benefit – 1199 Staff Workers – Wellnet Meritain Health – Wine Liquor Distillery Union

Their hospital affiliations are as follows:

Dr Arthur Lubitz: **Mount Sinai St Luke's, NYU Langone Medical Center, Lenox Hill Hospital**

Dr Ama Alexis: **Mount Sinai St Luke's, NYU Langone Medical Center, Bellevue Hospital**

Acknowledgement of Receipt:

Signature _____ Date _____

If Legal Representative, Indicate relationship to Patient _____

Print Name of Patient _____

Print Name of Legal Representative _____