Delaware Valley Allergy

www.dvallergy.com
Fax: 610-789-0655

400 W. Township Line Rd.
Havertown, Pa 19083
610-789-1313

Riddle Memorial Hospital
Health Center 2
Suite 2106
Media, Pa 19063
610-566-2126

Main Line Health Center
1020 Baltimore Pike
Suite 220
Glen Mills, Pa 19342
610-361-8300

Name (Last, First):	DOB:	Gender Assigned at birth (circle): M F Neither Current Gender Identification (circle): M F Non-binary
Street Address (Apartment if applicable): City: State, Zip:		
Cell Phone: Home Phone: May we leave voicemails? Y N		Email address:
Employer:		Work Phone Number:
Referring Physician Name: Referring Physician Phone Number: Referring Physician Address:		
Primary Care Provider (PCP): PCP Phone Number: PCP Address:		
Pharmacy:	Pharmacy Phone #:	Pharmacy Address:
Emergency Contact Name:	Phone Number:	Relationship to Patient:
Insurance Company Name:	Policy #: Group #:	Name on the policy: Relationship to patient:
Secondary Insurance (if applicable):	Policy #:	Name on the policy: Relationship to patient:

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Patient Name:	**DOB:**
Today's Chief Complaint:	

Medical History:	Surgical History:	
	Surgery:	Date:

Drug Allergies (Specify Below)	
Drug Name:	Reaction:

Food Allergy (Specify Below)	
Food:	Reaction:

Insect Sting Allergy		
Name of Insect:	Reaction:	How many times per day?

Medication List (continue on back if necessary)		
Name of Medication:	Dose:	How many times per day?

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Patient Name: DOB:

Social History:

Which of the following best describes your residence (please circle):
Single Family Home / Townhouse / Rowhome / Apartment / Other:

Type of Flooring: Hardwood / Laminate / Tile / Carpet

Problems with: Water Damage / Extensive Mold / Rodents /Roaches

Do you have pets at home? Y / N

Please specify number and types of pet(s):

What is your profession?
Are you exposed to caustic or irritating chemicals? Y / N Type:

Do you smoke? Y / N / Former # of Years Packs Per Day Quit Date
Are you/have you been exposed to second hand smoke? Y / N # of Years

Do you vape? Y /N /Former # of Years Miltr/day Quit Date:

Do you use marijuana? Y/N/Former How do you use it? Smoke/Ingest

Do you drink alcoholic beverages: Yes / No Rarely Socially Frequently

Recreational drug use? Y/N Type:

Family History (Check All That Apply):	Father	Mother	Sibling	Child
Allergic Rhinitis (Hay Fever)				
Asthma				
Atopic Dermatitis (Eczema)				
Food Allergy (Specify)				
Autoimmune Disease (Specify)				
Other (Specify)				

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient/Guarantor Signature

Date

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Notice of Privacy Practices
Patient Acknowledgment

Delaware Valley Allergy is required by law to provide patients with a Notice of Privacy Practices (NPP). In accordance with that law, we are obligated to maintain the privacy and security of your protected health information. You may request a written copy of our full policy at any time. By signing below, you understand the following:

At any time, you may request a copy of your medical records, ask us to correct your medical record, request confidential communications, ask us to limit what we use or share, obtain a list of the individuals or organizations with whom we share your information, choose someone to act on your behalf, and authorize a representative, or file a complaint if you feel your rights are violated.

We will never sell your information, nor use your information for the purposes of marketing or fundraising.

We will only use your information for your medical treatment, to run our practice, to bill for services, to adhere to public safety compliances, and to act in accordance with government/legal agencies as required by law.

_____

Patient Printed Name

_____ _____

Patient/Guardian Signature Date

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Patient Financial Responsibility Form

- Individual's Financial Responsibility
  - I understand that I am financially responsible for my health insurance deductible, coinsurance, co-pays and/or non-covered services.
  - I understand co-payments are due at the time of service.
  - I understand that if my insurance plan requires a referral, it is my responsibility to obtain it prior to my visit.
  - I understand that in the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and, agree to pay the costs of all services provided.
  - I agree to pay the medical services rendered to me at the time of service, if I am uninsured.
  - I understand that it is my responsibility to provide the office with up to date and accurate insurance and personal contact information. Additionally, it is my responsibility to notify the office if this information changes.
  - If I fail to provide or update the office with accurate insurance or personal contact information, and this results in rejection of a claim, I will be responsible for payment of my bill in its entirety.

- Insurance Authorization For Assignments Of Benefits
  - I hereby authorize and direct payment of my medical benefits to Delaware Valley Allergy (Thomas E. Klein MD, PC) on my behalf for any services furnished to me by the providers.

- Authorization To Release Records
  - I hereby authorize Delaware Valley Allergy (Thomas E. Klein MD, PC) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, needed to substantiate payment for all medical services provided to me, including: diagnosis, examination, and treatment records.

- Medicare Request For Payment
  - I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by Delaware Valley Allergy (Thomas E. Klein MD, PC). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____
Print Name of Patient, Authorized Representative or Responsible Party Date

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Advanced Care Planning Questionnaire

Name: _____ DOB: _____

Advanced Directives allow a patient to make decisions regarding their medical treatment during the most vulnerable time in their life. It is important for both families and doctors to understand a patient's instructions regarding medical treatment in the event they are unable to communicate for themselves. Two of the most important documents that may be used to express your wishes are the Living Will and the Durable Power of Attorney.

In the event of an emergency, a **Living Will** indicates to health care professionals which treatments they should or should not provide. It is a legal document that defines your exact wishes for medical care should you be unable to communicate.

Do you currently have a Living Will? Yes ____ No ____
If yes, it is our recommendation that you provide a copy of your Living Will to the people responsible for your medical treatment including your Primary Care Physician

A **Durable Power of Attorney** for healthcare allows a designee to make decisions regarding your medical care if you are unable to do so. This legal document may be used alone or in conjunction with a Living Will.

Do you currently have a Durable Power of Attorney for healthcare? Yes ____ No ____

If yes, please provide the name of your Medical Durable Power of Attorney. _____
If yes, it is our recommendation that you provide a copy of your Durable Power of Attorney to the people responsible for your medical treatment including your Primary Care Physician

The Living Will and Durable Power of Attorney forms are only two of the forms you may choose to use to convey your wishes for medical treatment in an emergency. It is important to plan for your future medical care, regardless of your age or health status. If you would like additional information regarding Advanced Directives, please speak with your health care provider or see the front desk for additional resources.

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Medical Records Release Form

I hereby request a copy of my medical records from Delaware Valley Allergy to be sent to the medical provider listed below.

Please provide the name and scope of requested medical information (i.e. all medical records, billing information, specific date of treatment) below:

_____

_____

_____

I hereby authorize Delaware Valley Allergy to release a copy of my medical records and/or completed medical form to the medical professionals below:

Practice/Physician Name: _____

Address: _____

Phone Number: _____

Fax: _____

_____
Patient's Name

_____ _____
Patient/Guardian Signature Date

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PHI Release Authorization Form

At my request, I hereby authorize Delaware Valley Allergy (Thomas E. Klein MD PC) to release my personal health information (PHI) to only those described below: *(check all that apply, identify person by first and last name)*

___ All of My Family _____

___ Spouse _____

___ Mother _____

___ Father _____

___ Children _____

___ Other (person or organization) _____

Information to be released (please circle):

All PHI, Doctor's Notes, Lab/Testing Results, CT Scan, X-Ray, MRI, Other Imaging Results (Specify)_____
Procedure Information & Results

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (collectively, "HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, the date of this Authorization and my signature and that I should send it to:

Delaware Valley Allergy
Attention: HIPAA Compliance Officer
400 W. Township Line Rd.
Havertown, PA 19083

I understand that I am not required to sign this Authorization and that my Treatment cannot be conditioned upon my execution of this Authorization.

I understand that the information Used or Disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and, in that case, will no longer be protected by HIPAA.

This Authorization expires within one (1) year, or earlier upon my request. I hereby acknowledge receipt a copy of this Authorization.

_____ _____
Printed name of Patient Printed name of Guarantor (If applicable)

_____ _____
Signature of Patient or Guarantor Date

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Communication Preferences Form

I authorize the following means of communication:

Primary Phone: _____
May we leave messages on this phone: Y/N

Secondary Phone: _____
May we leave messages on this phone: Y/N

Fax Number: _____
Personal/Business

Home Address: _____

_____

_____

Email Address: _____

_____
Patient Printed Name

_____ _____
Patient/Guardian Signature Date

Revocation of communication types may be made at any time by submitting a request in writing. I understand that my revocation must include my name, address, telephone number, date, and my signature and that the revocation should be sent to:
Delaware Valley Allergy
Attn: HIPAA Compliance Officer
400 W. Township Line Rd.
Havertown, PA 19083
It is the patient's responsibility to inform Delaware Valley Allergy of any changes to communication preferences.