Long Island Allergies
Dr. Annette Fiorillo-Quinn

***Long Island Allergies***
***2940 Lincoln Ave. Suite 200***
***Oceanside, NY 11572***
***P: 516-307-9140 F: 516 706-6770***
***Longislandallergies.com***

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**Date of Visit:** __ __ / __ __ / __ __

# Patient Information

Sex / Gender: ◊ Male ◊ Female
First Name: _____ Last Name: _____
Date of Birth: __ __ / __ __ / __ __ Social Security Number: __ __ __ - __ __ - __ __ __ __
Home Address: _____ Email: _____
City: _____ State: _____ Zip: _____
Home Number: _____ Cell Number: _____
Patient is: ◊Child ◊Single ◊Married ◊Separated ◊Divorced ◊Widowed ◊Domestic Partnership

## HOW DID YOU HEAR ABOUT US

How did you hear about us? ◊ Friend ◊ Family Member ◊ Internet ◊ Another Doctor
Name of person, doctor, company, or website: _____

## EMERGENCY CONTACT INFORMATION

First Name: _____ Last Name: _____
Relationship to Patient: _____
Home Number: _____ Work Number: _____

## PRIMARY DOCTOR INFORMATION

Family/Primary Care Physician: _____
City: _____ State: _____
Phone Number: _____ Fax Number: _____

## REFERRING DOCTOR INFORMATION

Referring Physician: _____
City: _____ State: _____
Phone Number: _____ Fax Number: _____

## INSURANCE AND RESPONSIBLE PARTY (SUBSCRIBER) INFORMATION

Primary Insurance: _____ Secondary Insurance: _____
Subscriber First Name: _____ Last Name: _____
Date of Birth: __ __ / __ __ / __ __ Social Security Number: _____
Home Address: _____ City: _____
State: _____ Zip: _____ Email: _____

## PREFERRED PHARMACY INFORMATION

Company / Pharmacy: _____
Address: _____ Phone Number: _____
City, State: _____ Fax Number: _____

# NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Health Insurance Portability and Accountability Act of 1996 (HIPA). Our Practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentially of your health record. We realize that these laws are complicated, but we must provide you with the following important information:

**The following circumstance may require us to use or disclose your health information:**

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

I,_____(the patient) acknowledge that I have received the Notice of Privacy Practice. I also have been given the opportunity to ask questions about personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Signature of Patient or responsible Party: _____

## YOUR RIGHTS AND HEALTH INFORMATION

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information to

only certain individuals involved in your care or the payment for your care, such as family member and friends.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing, but not including psychotherapy notes. You must submit your requests in writing to Dr. Annette Fiorillo-Quinn, 2940 Lincoln Avenue Suite 200, Oceanside, NY 11572 (or fax 516-706-6770)
4. You may be asked to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Annette Fiorillo-Quinn, 2940 Lincoln Avenue Suite 200, Oceanside, NY 11572 (or fax 516-706-6770). You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contract Dr. Annette Fiorillo Quinn, 2940 Lincoln Ave. Suite 200, Oceanside, NY 11572.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with out practice or with the Secretary of the Department of Health and Human Services. To file a complaint with out practice, contact Dr. Annette Fiorillo-Quinn, 2940 Lincoln Ave. Suite 200, Oceanside, NY 11572. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

## PATIENT/GAURANTOR AGREEMENT

1. On my own behalf and on behalf of my spouse and minor children, including stepchildren, I hereby authorize treatment by Dr. Annette Fiorillo-Quinn.
2. I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due to Dr. Annette Fiorillo-Quinn agree to pay all cost of collections including collection agency fees. I understand there is a $25.00 returned check fee should a check be returned for any reason.
3. I hereby authorize the release of any and all medical and/or charge information as is necessary for third party reimbursement from Medicare, Blue Shield and/or any other agency involved in the payment of my treatment.
4. I also direct and assign payment from said third parties to Dr. Annette Fiorillo-Quinn. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to Dr. Fiorillo-Quinn for any charges not covered by insurance. If payment from my insurance is not received within 120 days, my account will become due and payable by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. Charges not payable by my insurance carrier are due immediately.
5. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or body fluids. In the event of such exposure, State laws require a sample of my blood to be tested for the presence of infectious diseases. The results

of these tests will be released to me and my family and to the healthcare workers who suffered exposure.

6. The assignment/obligations and authorizations set forth in this statement and the insurance assignment shall be binding upon both me both for the present treatment and that which may be rendered to me and my family in the future by Dr. Annette Fiorillo-Quinn.
7. I authorize a copy of my medical record to be forwarded to my Primary Care Physician as well as any and all attending or consulting practitioners.
8. In attempt to see each patients promptly and in a timely fashion we ask for all cancellations to be made 24 hours before your scheduled appointment. Failure to do so will result in a $50.00 fee.

I hereby authorize direct payment to Dr. Annette Fiorillo-Quinn (doctor and/or any service provider) of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, including collection fees, court costs, attorney fees, and prejudgment interest at the highest amounts allowed under the law, whether or not paid by insurance, and for all services rendered on my behalf or my dependents'. I authorize the doctor and/or any service supplier in this office to release this information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Responsible party: _____

This is to advise you that it is your responsibility, as a patient, to obtain a referral from your Primary Care Physician for services rendered. This referral must be dated prior to the time of service. It is also your responsibility to keep track and make a copy of your referrals to be sure that the visits or length of time of the referrals do not run out.

If a referral is not obtained, you will be billed for the payment to the doctor.

Signature of Patient or Responsible Party: _____

Date: _____ Witness:_____