TO ALL NEW PATIENTS UNDERGOING EVALUATION FOR MAST CELL ACTIVATION DISORDER

Welcome!

The following is the policy for an appointment to undergo an evaluation with Dr. Anne Maitland.

1. All patients must have a written referral letter from their local physician. This letter and medical records should be emailed to operations@caac-nyc.com or faxed to the office of:

Dr. Anne Maitland, MD, PhD
The **fax number** is **914.337.8204**

If you have additional reports, please send these records :

- Recent office visit notes
- Blood test results
- Hospital and emergency room visits
- Biopsy reports
- Serum tryptase level, Serum histamine level
- A complete blood count with differential
- 24 hour urine tests for N-methylhistamine and 11-betaprostaglandin F2

2. Once your information is received and your questionnaire is reviewed, a representative from the office of Dr. Maitland will be in contact with you regarding when an appointment can be scheduled. **The fee for review of records and questionnaire is $325.00, which is collected through the payment of the Practice Admistrative fee**
(Annually $900 or semi-annually $450). The CPT code is 99358 for you to submit to your insurance.

*****Please note that no medical advice will be given nor will there be direct communication with patients who are not established with this practice*****

3. It is the patient's responsibility to verify appropriate insurance coverage and to obtain referrals, if necessary. The staff members of Comprehensive Allergy & Asthma Care are not able to call insurance companies to verify insurance coverage, for neither the office visit or any laboratory testing. The office also does not have the resources to arrange referrals.

4. All patients should be medically stable to travel to the appointment. No emergency appointments can be scheduled.

5. The patient must have a local health care provider - doctor, physician assistant, nurse practitioner- who will follow up when the patient returns home, to provide ongoing management and care.

6. The initial consultation visit typically is 60 minutes and the follow up appointment is approximately 30-45 minutes. The intention of of the follow up is to discuss any further test results, treatment recommendations, and to coordinate care with the health care provider who will be responsible for the patients' ongoing treatment and care.

7. Routine medications (including antihistamines) should **NOT** be stopped prior to the appointment.

Patient's Last Name ___________________________ First Name____________________ Middle Initial ________

SSN ________________ Date of Birth - Age ________ Sex F ☐ M ☐

Address Apt.#_________ City _______ State___ Zip ______ County_________

Pharmacy Name and address___

Name & Address of Primary Care (Family) Physician or Pediatrician _________________________

Name & Address of Referring Physician(if different)________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Student Status: ☐ PT ☐ FT

Phone _______________ Day Phone__________ Cell Phone

E-mail Address ___________________________

Employer: ___________________ Employer Address: __________________

What is or was your occupation? -_________________ ☐ DOB

Name of Spouse/Parent/Legal Guardian_________________________ SSN ______________

Primary Medical Insurance

Policy Holder Name________________________ Policy SSN________________ DOB________________

Ins.Name__________________________ Policy#____________ Patient#_________

Group Name ___________________________ Group Number ____________________

Ins. Co. Address ____________________ Ins. Co. Phone Number ______________ Effective Date __________

Co-pay _______ Deductible _______

Secondary Medical Insurance

Policy Holder Name_______________ Policy Holder SSN _______ Policy Holder DOB ________________

Plan Name _______ Policy Holder# __________ Patient's Policy #____________

Group Name Ins. Co. Group Number (if applicable) _____

Address_________________________ Ins. Co. Phone Number

Co-Pay Amount _______ Deductible

Is this visit covered by Workers' Comp? ______________________

Emergency Contact: Phone#: ___ __________________

I will pay by: Cash ☐ Check ☐ Charge ☐

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full

I have received Comprehensive Allergy & Asthma Care's notice of privacy practice,

*Responsible Party Signature*____________ Date

Patient Name:_____________________________ DOB:__________ Date:

Comprehensive Allergy & Asthma Care, PLLC
TEL 914.631.3283 || Fax 914.337.8204
www.drannemaitland.net

Patient Name:_______________________________

Patient date of birth:___________________________
Month / Day / Year

Address: ____

Contact Number:_________________ _________________ _____________________

Please choose one as primary ☐ *Home* ☐ *Mobile* ☐ *other*__________

E-mail Address:______________________________

Name and telephone number of physician______________________( )____________

Telephone Consultation Information

The initial consult is 45 minutes and costs a minimum of $650.00.
Review of Medical records, code 99358, carries a charge of $325.00 and is included in the 1st Practice Administrative Fee payment ($900) and will be collected upon receipt of the patient's forms and medical records. An appointment will then be given once all medical records have been reviewed.

- Payment for review of records will be collected **before** the appointment
- If the consult exceeds the 45 minutes, charges are $75 every **15 minutes** thereafter. Follow up telephone consultations are $575 for **45 minutes** and $75 every **15 minutes** thereafter.
- For non face-to-face communications, including patient portal messages, the charge is $75.00 for 10 minute discussion of test results and $100.00 to address new concerns.

**** You will be charged for the duration you are on the phone with our provider therefore payment of the phone consultation is due after your appointment, based expressly on the length of the telephone consultation ****

Insurance providers typically will NOT cover fees for telephone consultations with our health care providers.

We can provide an invoice print out, which can then be submitted to your insurance for reimbursement.

The office can provide an invoice on the consultations and follow up communications, that you can submit to your insurance company for reimbursement.

Please complete this form, and fax it back **at least 1 week prior** to your appointment.

By signing and returning this form you agree to these terms.

Patient/Guardian Signature: *X*________________________________

Credit Card (Mastercard or Visa)______________________________Exp__________ CVV_______

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional 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 financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST A PHOTOCOPY OF YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **APPOINTMENTS -** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $50.00 may then be added to your account.
- **REFERRALS -** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personal ly responsible for that day's services.
- **CO-PAYMENTS -** By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. **Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.**
- **OUT OF NETWORK PLANS -** You will be responsible for any balance your plan indicates is due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not participate with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.
- **Private Insurance Authorization for Assignment of Benefits/Information Release**: I, the undersigned, authorize payment of medical benefits to Comprehensive Allergy & Asthma Care, PLLC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS -** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE -** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Comprehensive Allergy & Asthma Care, PLLC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS -** The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Comprehensive Allergy & Asthma Care, PLLC, will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account Should ii become necessary for us to use. an outside agency to collect payment form you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us any special concerns.

Patient's Name:______________________________ DOB: ______________________

Responsible Party Signature: X______________________ Date: ______________________

Print Name: ______________________________ Relationship: ______________________

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

NEW YORK STATE DEPARTMENT OF HEALTH

Patient Name: ______________________ Patient Identification Number: ______________

Patient Address: ______________________ Date of Birth: ______________

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFI DENTIAL HIV/AIDS·RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.

2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment. or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment. enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: INSERT START DATE until INSERT EXPIRATIDN DATE OR EVENT

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs	______________	______
☐ Clinical records from mental health programs*	______________	
☐ HIV/AIDS-related Information	______________	

9. If not the patient. name of person signing form: ______________

10. Authority to sign on behalf of patient: X ______________

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW X ______________ DATE ______

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND Title ______________ SIGNATURE X ______________ DATE ______

This form may be used in place of DDH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information, Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pur5uant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Comprehensive Allergy & **Asthma Care** (tel) 914.631.3283 (fax) 914.631.3284

Please DO NOT use Patient Portal to communicate with our Practice for urgent or emergency medical issues. If you are experiencing an urgent medical need, please contact us by phone. For emergencies call 911.

Patient Portal User Agreement and Consent

Effective: January 1, 2020

Comprehensive Allergy & Asthma Care, PLLC provides this site in partnership with Athena Health® for the exclusive use of its established patients. The patient portal is designed to enhance patient· physician communications. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information.

The information on the patient portal is maintained by Comprehensive Allergy & Asthma Care, PLLC at its current site at 200 South Broadway, Suite 104, Tarrytown, NY 10591. For questions about this site, contact our office, at 914-631-3283.

The patient portal does provide the following services:

- Medication refill request
- Communication of laboratory results from staff to patient
- Review Patient's medical summary, medication list, treatment history and visitation dates
- Schedule requests, patient directed scheduling, and waiting list requests
- Limited communication regarding on-going treatment **initials** _____
- **Physician or professional staff communications may incur charges based on scope of requested service. Initial______**

The patient portal is not intended to provide internet based diagnostic medical services. Also following limitations apply:

- No internet based triage and treatment requests. Diagnosis can only be made and treatment rendered after the patient schedules and SEES the doctor.
- No Emergent communications or services. Any emergent conditions should be seen by Urgent Care, Emergency Department, or 911.
- No request for narcotic pain medication will be accepted.
- Request for re-fill medication not currently being treated by the physician. **initials____**

We are focused on providing highest level of service and health care and provide access to the patient portal is as a courtesy to our valued patients.

However, please be advised that if questions involving more extensive interpretation of tests, ongoing treatment, or new symptoms, a charge will be applied (typically $50.00 to 75.00, using the code 99444 for non face-to-face EM code). **Initials ____**

In addition, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal. Initials ____

The patient portal is provided in partnership with our EHR software vendor and provider. The data is on a

HIPAA compliant server with high level encryption that meets or exceeds the HIPAA standards.

While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent that it is possible, Comprehensive Allergy and Asthma Care, PLLC has undergone rigorous IT implementation and meets or exceeds security standards .

Please read our HIPAA policy for information on how private health information (PHI) is used at Comprehensive Allergy & Asthma Care, PLLC. All new and established patients have signed HIPAA agreement form and have been given a copy of our HIPAA policy. If you do not recall having signed HIPAA agreement please sign and date this copy for our records.

Access to Online Communications

The following pertains to access to and use of online communications: Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement all of my questions have been answered and I understand and concur with the information.

Print Patient Name: ___________________________ Date of Birth _______

Email address: ________________________________

Signature X________________________ Relationship________________ Date______________

I am over the age of 18 and have sole responsibility of my medical care ☐Yes ☐No (We do not offer the Patient Portal to minors or those patients which do not make their own medical decisions at this time. We apologize for the inconvenience.)

I choose not to participate in Patient Portal at this time because: ☐I do not have an E-mail address ☐1 do not wish to share my E-mail address ☐English is not my preferred language ☐Other_______________