

Anjuli S. Nayak, MD
 2010 Jacobssen Drive, Normal, IL 61761
 Phone:309-452-0995 fax: 309-862-0961
www.asthma2.com e-mail: office@asthma2.com

New Patient Cancellation Policy

Welcome to our practice and thank you for choosing us! We appreciate your confidence and goodwill. Your appointment will take approximately 2-4 hours.

- **Patients must give at least 24 hours notice; please call 309-452-0995.**
- **Patients who are 15 (or more) minutes late may have to be rescheduled.**

Patient Instructions for New Patients/Skin Testing

5 days before your testing appointment please stop taking the following medications:

- **Antihistamines, Decongestant/antihistamine combination medications, *see list below***
- **Astelin/Astepro**, a prescription nose spray antihistamine
- Any **over the counter allergy medicines, cold & cough remedies**
- Any **over the counter sleep aids**, they usually contain a sedating antihistamine
- **Vitamin C**, if you are taking **1000 mg or more**: large doses act as a natural antihistamine

Please review these lists of medications. If you are not certain if you are taking a product that contains an antihistamine, ask your pharmacist or call this office.

Contain antihistamines	Decongestant/Antihistamine combinations	Other Medications	
Actifed (Triprolidine) Alavert Allegra (Fexofenadine) Antivert or Bonine (Meclizine) Astelin/Astepro (dispensed as a Nose Spray) Atarax (Hydroxyzine) Benadryl (Diphenhydramine) Bromfed (Brompheniramine) Chlortrimeton (Chlorpheniramine) Claritin (Loratidine) or Clarinx Dramamine (Dimenhydrinate) PBZ (Tripelenamine) Patanase Periactin (Cyproheptadin) Phenergan (Promethazine) Polyhistine (Phenyltoloxamine) Semprex (Acrivastine) Tavist (Clemastine) Tylenol PM Unisom (Doxylamine) Zyrtec (Cetirizine)	Allegra D Claritin D Naldecon Polyhistine D Rynatan Tavist D Trinalin Repetabs Zyrtec D Most over the counter cold, cough medications	Anafranil Axid Bromphen Compazine Duravent Elavil Haldol Hismanal Midol Norpramin Optimine Optivar Pamelor Pamprin Panamist Pannaz Patanol Pepcid Phenergan Seldane	Sinequan Sominex Tagamet Temaril Thorazine Toranil Visine Allergy Zantac

You should continue to take as prescribed the following medications:

- **Antibiotics**
- **All asthma medications**
- **Prescription nose sprays**, with the exception of **Astelin/Astepro**, which is an antihistamine
- **Decongestants that are not combined with an antihistamine**

Please dress accordingly: skin testing is usually performed on your back.

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Patient Information

Patient Name _____ Home Phone: _____

Patient SS # _____ Work Phone: _____

Mailing Address: _____ Cell Phone: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Birth date: _____

Sex: Male Female

Responsible Party _____ Relationship: _____

Responsible Party Address _____

Responsible Party Phone: _____

Who may we thank for referring you? _____

In Case of An Emergency, Contact: _____ Phone: _____

Insurance Information

All co-pays and self-pay services are expected to be paid the day of service

Primary Care Physician: _____ Phone #: _____

Address: _____

Primary Insurance Company

Secondary Insurance Company

Subscriber: _____

Subscriber: _____

Date of Birth: _____

Date of Birth: _____

Social Security # _____

Social Security # _____

ID# _____ Group # _____

ID# _____ Group # _____

Copay \$ _____ Co-Ins \$ _____ Copay \$ _____ Co-Ins \$ _____

Assignment And Release

I, the Undersigned, have my insurance with _____

(Name of Insurance Company)

and assign directly to the **Anjuli S. Nayak, MD** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature

Date

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment on your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

- ◆ We accept cash, checks, MasterCard, and Visa
- ◆ We offer an extended payment with prior approval
- ◆ Your co-payment is due at the time of service.
- ◆ All immunotherapy vials need to be paid for if they are to be taken out of the office.

Regarding Insurance

Whether your insurance pays or not, you are responsible for the appropriate balance. We do require your co-payment or co-insurance (10%, 20%, etc.) to be paid at the time of service. Please be aware of the requirements of your plan. We cannot bill your insurance unless you bring all of your insurance information. Your insurance policy is a contract between you and your insurance company; we may or may not be an "IN NETWORK" provider. It is your responsibility to verify whether we are an "IN NETWORK" provider. Please be aware that some, perhaps all of the services provided may be non-covered services and not considered reasonable and customary under the Medicare Program and/or other medical insurance.

Patients who wish to submit claims themselves must pay in full at the time of service, unless other arrangements are made.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our specialty. You are responsible for the appropriate contracted or billed charges regardless of any insurance company's arbitrary determination of usual and customary rates.

Once balance becomes patient responsibility, the account must be paid in full within three (3) months to keep account out of collections. If your account must be turned over to a collection agency, you will be held responsible for collection fees of 35% of the total balance due. In addition, you will be held responsible for any legal and court fees.

Our nurse practitioner/physicians' assistant, may see you independently, but Anjuli S. Nayak, M.D, endorses all of his/her clinical decisions.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to the Financial Policy.

X _____ Date: _____
Signature of Patient or Responsible Party

Printed Name of Patient or Responsible Party

X _____ Date: _____
Signature of Co-Responsible Party

Printed Name of Co-Responsible Party

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from
Print Patient Name
Anjuli S. Nayak, MD.

X _____ **Date:** _____
Signature of Parent /Legal Guardian/Authorized Person

I wish to be contacted in the following manner (check all that apply).

- | | |
|--|--|
| Home: Phone: _____ | Work: Phone: _____ |
| <input type="checkbox"/> OK to leave message with detailed information | <input type="checkbox"/> OK to leave message with detailed information |
| <input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Leave message with call back number only |
| <input type="checkbox"/> OK to fax home: _____ | <input type="checkbox"/> OK to fax work _____ |
| <input type="checkbox"/> OK to mail my home address | <input type="checkbox"/> OK to mail my work address |

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Anjuli S. Nayak may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to such. In that case, Anjuli S. Nayak will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to such. I designate the following persons listed below as persons involved in my health care or payment relating to such. For the purpose of Anjuli S. Nayak, MD making the limited disclosures described above. (I understand that I am not required to list anyone and that I may change this list at any time in writing.

Print Name of each designated person below:	Date of birth:

Staff Only:

In lieu of patient signature, I, _____, a staff member of
Print Name of Staff Member

Anjuli S. Nayak, MD, state that _____ has been given our current Notice of Privacy Practices.

Date: _____