ALLERGY AFFILIATES, INC.
Geetika Sabharwal, M.D.

Adult & Pediatric Allergy, Asthma & Immunology
www.allergyaffiliates.com

West Office:
6220 Manatee Ave W Suite 201
Bradenton, Florida 34209

(941) 792-4151
(941) 792-8463 (Fax)

East Office:
5229 4th Avenue Cir E
Bradenton, Florida 34208

Dear New Patient,

Thank you for scheduling an appointment with our office!

Please arrive 15 minutes before your scheduled appointment time to allow time for us to get you registered and to make copies of all your insurance card(s) and photo ID. If you are unable to keep this appointment, please provide 24-hour notice of cancellation. Details about our cancellation policy are included in our Appointment Policy.

Please complete the enclosed patient information and history forms.

If your insurance requires authorization, please call us 24 hours prior to your appointment to make sure we have received insurance authorization from your primary physician.

What to expect on the day of your appointment:

- Please bring a current list of medications.
- Anticipate being in the office for up to two hours for a comprehensive new patient evaluation. Feel free to bring items for your comfort at the visit (book, phone charger, jacket etc)

Allergy skin testing may be done on the day of your appointment. If you are taking ANTIHISTAMINES or MEDICATIONS THAT CONTAIN ANTIHISTAMINES such as over the counter sleep aids, for example Tylenol PM, you MUST DISCONTINUE their use **5-7 days** prior to your appointment.

Oral Antihistamine Medication:

Allegra/Allegra D (fexofenadine)	**Benadryl (diphenhydramine)**	**Clarinex/Clarinex D (desloratadine)**
Claritin/Claritin D (loratadine)	**Xyzal (levocetrizine)**	**Atarax (hydroxyzine)**
Periactin (cyproheptadine)	**Zyrtec/Zyrtec D (cetirizine)**	**Quercetin**
Dimetapp (contains brompheniramine)	**Chlorpheniramine**	**Alka seltzer Plus (contains doxylamine)**
Tylenol Cold and Sinus	**Tylenol PM**	**Advil Cold and Sinus**
Advil PM	**Meclizine**	**Dramamine**
Promethazine	**Nyquil**	

Antihistamine Nasal Sprays:

Astelin (azelastine HCl) nasal spray	**Astepro (azelastine HCl) nasal spray**	**Dymista (contains azelastine HCl)**
	Patanase (olopatadine HCl) nasal spray	**Ryaltris (olaptadines, mometasone nasal spray**

Antihistamine Eye drops:

Azelastine	**Epinastine**	**Ketotifen**	**Naphcon-A**	**Olopatadine**	**Elestar**	**Pazeo**
Bepreve	**Opcon-A**	**Optivar**	**Pataday**	**Patanol**	**Visine-A**	**Zatidor**

You should **NOT** discontinue any other medications you are taking. Please call if you have questions as to whether your medications contain antihistamines.

Sincerely,

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PATIENT INFORMATION

Name_____ Age_____ Date of Birth_____
(Last, First, Middle)

SS#_____ Marital Status_____ Sex M/F_____

Home Address_____
(Street, City, State & Zip)

Daytime Phone_____ Cell*/Home Phone_____ Work Phone_____

Email Address* _____

*I am fully aware that cell phone and unencrypted emails are not considered secure forms of communication under applicable law. By providing this information, I understand the risks and consent to being contacted this way, including receiving appointment reminders. If I do not consent to this, I will consult with office staff.

Occupation_____ Employer_____
(Name and Address)

Race _____ Ethnicity Hispanic/Latino Not Hispanic/Latino Decline to answer_____
(circle one)

Northern Address_____(if applicable)

PARENT/SPOUSE INFORMATION

1. Name_____ Relationship to Patient_____
2. Name_____ Relationship to Patient_____

EMERGENCY CONTACT INFORMATION

1. Name_____ Relationship to Patient_____
   (Last, First, Middle)

   Home Phone_____ Work Phone_____

2. Name_____ Relationship to Patient_____
   (Last, First, Middle)

   Home Phone_____ Work Phone_____

REFERRAL INFORMATION
Who referred you to our office?_____

PRIMARY CARE DOCTOR: _____

PHARMACY: _____

INSURANCE INFORMATION: Please submit all insurance cards so that we may copy them for our records.

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Today's Date: _____

Patient Name:_____Age:_____Birth Date:_____Sex: M F

Name of Primary care Doctor:_____Provider's Phone Number:_____

Doctor you were referred by:_____Provider's Phone Number:_____

Allergy/Immunology History
What is the main reason for your visit?_____

_____

When did the symptoms begin? _____

Are you having problems with any of the following? Please circle the ones that apply.

1. Ears, eyes, nose, throat

- Ears: popping itching fluid
- Eyes: red itchy teary puffy
- Nose: congestion runny nose itching sniffing sneezing
- Throat: Drainage itchy throat/mouth frequent sore throat

Triggers for your symptoms:

Dust mold/mildew animals weeds cut grass outside pollen weather change

bleach strong smells air conditioning perfumes smoke eating meals other

2. Chest: asthma shortness of breath wheezing chest tightness cough

3. Skin: itching rash hives swelling eczema

4. Reaction to food: itchy mouth itchy throat rash swelling nausea vomiting diarrhea

What foods ? Please list: _____

5. History of Recurrent Infections: Pneumonia_____Sinusitis_____Ear Infection_____Skin Infection_____Blood Infection_____

6. Reaction to stinging insects (honeybee, wasps, hornet, yellow jackets):

- large local reaction: local rash_____ redness_____ swelling_____
- systemic reaction: widespread rash/swelling_____throat closing_____wheezing_____loss of consciousness_____

Medications/Treatments tried for your symptoms? Please list:

_____

_____

_____

Prior allergy testing? Yes No **Prior allergy Shots?** Yes No

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Patient Name: _____ Today's Date: _____

Past medical Problems

_____
_____
_____
_____

Surgeries/Hospitalizations (Specify Year)

_____
_____
_____
_____

Immunization History:

COVID-19 status _____
Tetanus status _____
Pneumovax status _____
Prevnar status _____
Flu status _____
Shingles status _____

Current Medications – please list(or attach list):

Name Dose Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medications(specify reaction):

_____
_____

Family History of allergic disease: (Please indicate which family member)

hay fever _____ asthma _____ eczema _____
hives _____ food allergy _____ insect allergy _____

Social History

Marital Status: S M D W Children: _____ Type of job: _____

- Minor: Current Grade: _____ School: _____ Sports: _____

Cigarettes: Currently? Yes No Amount _____ How Long? _____
Previously? Yes No Amount _____ Quit when? _____
Do you drink alcohol? Yes No Amount _____
Do you live in Florida year round? Yes No How long in Florida (specify year)? _____

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Patient Name: _____ Today's Date_____

Environmental History

City where you live:_____House Condo Apt Mobile Home
How many years in current home(what year)?_____

Pets	Yes No	Please list:_____	
Feathers in bedding	Yes No		
Mattress	regular (inner spring)	air water bed	foam rubber other
Flooring	carpet	hard floors both	
Is your air conditioning	central air	wall unit	

Review of System

If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY,** or explain any that may not be listed.

General	No Problems	Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats. Others_____
Eyes	No Problems	Glaucoma, vision change, Itchy eyes, cataract, watery eyes. Others_____
Ears, Nose, Mouth &Throat	No Problems	Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, ear pain, nosebleeds, sore throat, facial pain or numbness. Others_____
Heart	No Problems	Irregular Heart beat, racing heart, chest pains, swelling of feet or legs, Others_____
Lung	No Problems	Shortness of breath, cough, wheezing, sputum production, coughing up blood, Others_____
Abdomen	No Problems	Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, Incontinence. Others_____
Genitourinary	No Problems	Painful urination, frequent urination, urgency, prostate problems, bladder problems. Others _____
Musculoskeletal	No Problems	Joint pain, swelling of joints. Others_____
Skin	No Problems	Rash, itching, dry skin, eczema. Others_____
Neurologic	No Problems	Headaches, weakness, dizziness, tremor, loss of function or sensation. Others_____
Mental Status	No Problems	Insomnia, depression, anxiety, confusion. Others_____
Endocrine	No Problems	Intolerance to heat or cold, menstrual irregularities, frequent hunger/ urination/ thirst, changes in sex drive. Others_____
Blood	No Problems	Easy bleeding, easy bruising, anemia. Others_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,
HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on June 15, 2014 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Geetika Sabharwal, MD. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for each page and the staff time charged will be $15.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

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Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment, or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be charged in amounts allowable under HIPAA implementing regulations and in conformity with the HIPAA policies and procedures of this practice. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name:	Allergy Affiliates, Inc.	Privacy Officer: Geetika Sabharwal, M.D.
Telephone:	941-792-4151	Fax: 941-792-8463
Email:	admin@allergyaffiliates.com	
Address:	6220 Manatee Avenue West, Suite 201, Bradenton, FL 34209	

HIPAA Notice of Privacy Practices

This form is intended to comply with all appropriate provisions of the HIPAA Omnibus Final Rule.

Revised 05/05/2023

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____ _____
Signature *Date*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

_____ _____
Employee signature *Date*

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Revised 05/05/20234

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (print): _____

Date of Birth: _____

By signing this Authorization Form ("Authorization"), I understand that I am giving my authorization to Allergy Affiliates, Inc., its employees, designees, agents, independent contractors, legal representatives, successors, and assigns ("Practice") to use and/or disclose my protected health information as described in more detail in the paragraphs below, to the following person(s) or organization(s):

I authorize the Practice to disclose my medical records as defined under relevant federal and state law, including office notes, intake paperwork, laboratory and testing results, and reports, and diagnostic studies, to my other treating or referring health care providers.

Right to Revoke: I have the right to revoke this authorization at any time by providing written notice of my revocation to the address listed below:
6220 Manatee Ave W Suite 201
Bradenton, Florida 34209

Please understand that revocation of this Authorization will not affect any action Practice took in reliance on this Authorization before receiving my revocation.

This Authorization will expire when I revoke it in writing.

I hereby hold harmless and release Practice from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this Authorization.

If neither federal nor state privacy laws apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy law.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.

This Authorization is voluntary and I may refuse to sign this Authorization form.

If I am providing authorization for marketing purposes, I understand that Practice may receive remuneration from a properly authorized business associate as a result of using or disclosing my protected health information.

I understand that my refusal to sign this Authorization will have no effect on the medical treatment I receive from Practice.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative (*if applicable*) Date

_____
Printed name of Patient's Representative *(if applicable)*

_____
Relationship to patient *(if applicable)*

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Appointment Policy

Arrival Time: Please arrive 15 minutes prior to your appointment to complete paperwork and get checked in so that your treatment can begin on time. We will allow a 10-minute grace period from the time your appointment is scheduled to begin for patients who arrive after their scheduled time ("Late Arrivals"). We will do everything we can to accommodate Late Arrivals, however, if we do not have enough time to provide a quality treatment without impacting other patient appointments, we may need to cancel your appointment and reschedule.

Changes, Cancellations, and No-Shows: A 24-hour notice is required for any appointment changes or cancellations. A cancellation fee of $75.00 will be charged for any no shows and for any changes or cancellations made within 24 hours.* Any outstanding late fees on your account will need to be paid at the time of your next appointment.

Dismissal: Patients who violate this policy or fail to pay the missed appointment fee, may be subject to dismissal from the Practice. Patients who arrive late, miss, or cancel appointments without sufficient notice on three or more occasions may be dismissed from the Practice, subject to physician review.

Emergencies: We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office at the above-listed numbers and a Practice representative may be able to waive the fee, based on the circumstances. Documentation of the emergency, including but not limited to a doctor's note, etc., may be required to receive a full waiver. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Patient Consent: I hereby acknowledge that I understand and accept the polices above and that these policies will remain in effect for as long as I am a patient of the Practice, unless otherwise notified. I have read the Appointment Policy and agree to its terms.

Patient Signature: _____ **Date:** _____

Printed Name: _____

*If you are a Medicaid patient, cancellation fees do not apply to you. Please see office staff for details.

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Financial Policy

Revised 05-31-2023

Appointment Requirements

All registration and intake forms must be completed before seeing the doctor, including providing any applicable insurance information.

The full patient portion of your payment is due at the time of service. You are responsible for knowing in advance what portion of your treatment is covered by insurance and what you are responsible for.

For minors, the adult accompanying the minor to the appointment is responsible for the full payment.

Insurance

All payments are due prior to treatment. You must provide us with your insurance information (if you have insurance) at least 24-hours prior to your appointment.

It is your responsibility to keep your insurance information up to date with our office. If you fail to provide us with updated, accurate insurance information within 30 days of your treatment, you may be responsible for your treatment costs.

In the event that we do not accept assignment of benefits, we require that you be pre-approved on an extended payment plan or provide a credit card with authorization to bill that account for any balance due.

Please keep in mind that a quote of benefits or a pre-authorization do not guarantee payment or verify eligibility.

If your insurance company has not paid an office visit within 60 days, the balance may be automatically transferred to your account.

Statements

When you receive an explanation of benefits from your insurance company showing any patient responsibility, you are responsible for paying the patient portion, if not, you will receive a statement within the month for that amount. Statements for copayments or deductible amounts must be paid within 30 days of the statement date.

If you have an account balance with our office, we will send you a statement, notifying you of the balance. Payment is due within 30 days of the statement date.

There will be an additional $35 charge for checks denied by your bank and returned to the office for any reason.

Account Balances

Co-pays and balances are due at the time of your appointment. Other balances, if applicable, are due within 30 days of the date of your statement.

Payments must be made in full at the time services are rendered. If you fail to pay your cancellation fee as described above, your account may be sent to collections. By providing your card information to the Practice, you consent for the Practice to charge your card for any payment you owe to the Practice.

If you fail to pay what is due on your account, the Practice may be forced to utilize an outside collection agent or attorney. If attorney services become necessary to collect on your account, the Practice will add an additional 40% fee, up to $150, to your account.

If your account accrues a credit balance, the Practice will maintain that balance on your account and apply it to any future balance which may accrue. Small credit balances of $10 or less carried forward for more than two calendar years will be adjusted.

These policies are designed to comply with the Fair Debt Collection Practices Act and applicable state laws.

Consent

You understand that by providing your credit card information to the Practice, you consent for the Practice to charge your card for any payments you owe to the Practice, including, but not limited to co-pays, balances, and deductible amounts.

You understand that the Practice, or its debt-collecting representative, will call to collect any balances on your account and you consent to being contacted for that purpose at the number you provided.

You understand it is your responsibility to keep your contact information up to date.

You understand that if you fail to respond to the Practice's call regarding your balance within two business days,

ALLERGY AFFILIATES, INC.
Geetika Sabharwal, M.D.

Adult & Pediatric Allergy, Asthma & Immunology

www.allergyaffiliates.com

West Office:		**East Office:**
6220 Manatee Ave W Suite 201	**(941) 792-4151**	5229 4th Avenue Cir E
Bradenton, Florida 34209	**(941) 792-8463 (Fax)**	Bradenton, Florida 34208

your card will be charged accordingly.

Patient Consent: I hereby acknowledge that I understand and accept the polices above and that these policies will remain in effect for as long as I am a patient of the Practice, unless otherwise notified. I have read the Financial Policy and agree to its terms.

_____ _____

Signature of Patient, Parent or Guardian Date