Allergy, Asthma & Immunology Center, PC
Vital Prospects Clinical Research Institute, PC
Iftikhar Hussain, MD
Cristina Barnes, APRN
Ahmad Masood, DO

Name: _____ DOB: _____ Date: _____

Please list adverse reactions to any drugs, foods, or insect stings:

_____

_____

Current Medications:

Medication	Dose	Frequency	Indication	Start Date	Stop Date

Medical History (Diagnosis):

_____

_____

Surgical History (Procedure):

_____

_____

Any Communicable Diseases? HIV AIDS HEP C OTHER:_____

Social History:(Please Circle)

Smoker? Yes No **If Yes:** How many per day? _____

Date started? _____ Date stopped? _____

Alcohol Consumption? Yes No

Recreational Drug? Yes No

Caffeine Intake? Yes No

Exercise? Yes No

Sexually Active? Yes No

Type of residence? House Condo Apartment Trailer Other: _____

Travel outside the United States? Yes No **If Yes: Where?** _____

REVIEWED BY: _____

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Name: _____ DOB: _____ Date: _____

Review of Symptoms (Please circle)

Allergy	ENT	Neurology	Respiratory
Runny Nose	Cold	Headache	Chest Pain
Scratchy Throat	Cough	Seizures	Cough
Itchy Eyes	Nose Bleeds	Insomnia	Wheezing
Sneezing	Hearing Loss	Tic / Twitching	Shortness of Breath
Ear Fullness	Change in Voice	Memory Changes	Chest Congestion
Sinus Congestion	Sore Throat	Tingling/Numbness	Dyspnea
Sinus Drainage	Ringing in Ears	Dizziness	Sleep Disturbance
Itchy Nose	Sinus Pain/Headaches		Difficult to breath lying down
Endocrinology	**Cardiology**	**Gastroenterology**	**Psychology**
Fatigue	Dizziness	Nausea	Depression
Excessive Thirst	Chest Pain	Heartburn	Anxiety
Weight Loss	Palpitations	Hemorrhoids	High Stress
Sleep Disturbance	Rapid Heart Rate	Vomiting	Sleep Disturbance
Cold Intolerance	**High Blood Pressure**	Blood in Stool	Suicidal Thoughts
Heat Intolerance	Low Blood Pressure	Diarrhea	Substance Abuse
Diabetes	Leg Edema	Abdominal Pain	Eating Disorder
Thyroid Disorder	Leg Pain	Constipation	Agitation/Irritability
Urology	**Hematology**	**General**	
Recurring UTI	History of Anemia	Weight Gain	**Aneurysmal Vascular Disease or Arteriovenous malformation** including Thoracic or abdominal aorta, intracranial & peripheral arterial vessels
Blood in Urine	Swollen Glands	Weakness	
Difficult Urinating	Easy Bruising	Loss of Appetite	
Frequent Urination	Other:	Fever	
Nocturia		Breastfeeding	
Ulcerative/Interstitial Cystitis			**Hypersensitivity to esketamine, ketamine or any other excipients**
			Intracerebral Hemorrhage

REVIEWED BY: _____

MIND REJUVENATION

Tried and Failed Med List

Date ____________________

Name ____________________

DOB ____________________

Med	Started	Ended	Reason stopped taking med

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Registration Form & Policies (Please Print Legibly)

Name (last, First, MI): _____ Date: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ Appartment # _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Gender: Male Female

Employer: _____ Occupation: _____

Marital Status: Single Married Widowed Divorced Other _____

Ethnicity: Non-Hispanic Hispanic or Latino Refuse to report Other _____

Race: White Black or African American Hispanic American Indian Asian Other _____

Primary Care Physician: _____ **Referring Physician:** _____

Reason for today's visit: _____

Your goals for your treatment: _____

_____

_____
Patient Signature

MIND REJUVENATION

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HIPAA Right of Access Form for Family Member/Friend

Please list below any person(s) to whom we may inquire and/or inform about your general medical information, conditions or diagnosis. (PLEASE NOTE: These will be listed as Emergency Contacts UNLESS you specify below)

Name: _____ Relationship: _____ Cell: _____

OPTIONAL: Information to be released to above, IF ANY (please initial ONE)

_____ Complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment & billing)

_____ Complete health record as above, EXCEPT mental health, communicable diseases, alcohol/drug abuse treatment

Name: _____ Relationship: _____ Cell: _____

OPTIONAL: Information to be released to above, IF ANY (please initial ONE)

_____ Complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment & billing)

_____ Complete health record as above, EXCEPT mental health, communicable diseases, alcohol/drug abuse treatment

AFTER REVIEWING EACH SECTION BELOW, PLEASE INITIAL.

_____ (Initial) **AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION:** I authorize AAIC to release my medical information and/or individually identifiable health information to me(us) or my(our) duly authorized representative (as noted above), above), representatives of local, state, or federal agencies and insurance companies or other organizations or entities as may be required to be permitted under federal or state law or for review or payment of claims. I further authorize AAIC to release such information to physicians, hospitals or healthcare providers in order to treat me or to review my treatment. I understand that the specific information to be released may include, but is not limited to, history, diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I also understand I may revoke this authorization with a written and dated notice except to the extent that disclosure of information has been made prior of receipt of revocation.

_____ (Initial) **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONDITIONS OF TREATMENT:** The Notice of Privacy practices provides specific information and complete description of how my personal health information may be used and disclosed. I(we) acknowledge that upon my request I(we) have been provided and have reviewed the Notice of Privacy Practices (dated June 1, 2018) and Conditions of Treatment. I(we) understand that as part of my healthcare, AAIC maintains health records describing my health symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand this information is used to plan my care and treatment and to bill for services provided. It is also used to communicated with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals as required or permitted by law without my consent.

_____ (Initial) **AUTHORIZATION TO CONTACT PATIENT OR ACCOUNT REPRESENTATIVE:** I (we) hereby authorize AAIC physicianc and staff to leave detailed information by mail, phone, text or email regarding lab results, clinical information and account balance(s).

PRINTED name of person completing form _____ **Patient (Parent/Guardian) Signature** _____

Relationship to patient _____ **Date** _____

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2023 FINANCIAL POLICY

Allergy, Asthma & Immunology Center, P.C./Mind Rejuvenation is extremely pleased to provide care to you and your family. The following outlines our clinic's financial policy for 2023.

• We must emphasize that as a medical practice, our relationship is between you and AAIC/Mind Rejuvenation providers, not the insurance company. While filing insurance claims is a courtesy that we extend to our patients, it is ultimately your responsibility to understand your policy benefits. AAIC/Mind Rejuvenation contracts with most major insurance companies. **It is your responsibility to verify that our office is in network with your insurance carrier.** AAIC/Mind Rejuvenation is an independent private practice clinic and strongly recommends that patients check your insurance benefits and exclusions in advance. ***Patients are responsible for any portion of charges deemed non-covered or noted as "patient responsibility."*** *Services listed as "covered" by your plan are still subject to the patient financial liability for deductibles, co-insurance, and co-payments (as outlined per your plan).*

• Once record of insurance has been established it will be your responsibility to notify us of any changes. If you neglect to do so, you will be fully responsible for any amount rejected by insurance.

• **All co-payments are due at the time of service**.

• Once your claim has been processed you will receive a statement of patient responsibility for services provided. Payment in full is expected upon receipt of statement(s). AAIC/Mind Rejuvenation accepts payment by cash (in office only), check or credit card including Amex®/ Care Credit/ Discover®/ MasterCard®/Visa®. Payments can be taken by phone (918) 392-4550. **A $30 service fee will be added to all checks returned for insufficient funds.** If your check is returned, you will be required to pay cash, money order or credit card for services.

• **If your insurance company does not respond within 30 days after your claim is filed, payment will become your responsibility. Any amount remaining after insurance has paid or denied a claim will be expected to be paid upon receipt of your statement unless other arrangements are made with our office. If you are unable to pay your balance in full upon receipt of your statement, please call to speak with our staff to set up a monthly payment plan.**

• *Patients with unpaid delinquent balances after 90 days will be sent to a collection agency and patient is responsible for up to* ***60% collection agency fees*** *in addition to the account balance.* ***All unpaid balances are subject to Small Claims Court****. Satisfactory payment arrangements or account balance settlement are required before receiving any future services.*

We are committed to providing our patients quality care. By informing you of our expectations, we hope to alleviate any misunderstandings concerning your financial responsibility. Should you have questions about your account, please contact our office at (918) 392-4550.

I authorize release of any information necessary to process claims and direct payments to Allergy, Asthma & Immunology Center, P.C./Mind Rejuvenation I understand that I am responsible for all charges, regardless of insurance coverage.

I understand and agree to the terms of this financial policy.

_____ _____

Patient Signature Date

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No-Show & Co-Pay Policy

Patient Name: _____ Date: _____

All office visit co-pays will be due at the time of the service.

Please be considerate of other patients when canceling or rescheduling an appointment. Any appointment not cancelled or rescheduled at least 24 hours in advance could be charged a **$100 No-Show Fee**. This fee must be paid in full immediately.

The No-Show Fee is the responsibility of the patient. No insurance will pay for this fee.

I understand and agree to the terms of this financial policy.

_____ _____

Signature of patient or responsible party Relationship to patient