ASHA GUPTA MD FAAAAI

BOARD CERTIFIED IN ALLERGY & IMMUNOLOGY

260, RIVERSIDE DRIVE, JOHNSON CITY, NY 13790
PHONE 607-798-7811 FAX 607-770-7035

IMPORTANT INFORMATION ABOUT YOUR APPOINTMENT

PLEASE HELP US SERVE YOU EFFICIENTLY:

- Please fill out and print the PATIENT IFORMATION FORM and the MEDICATION AND ALLERGY LIST and bring them with you to the office on the day of your visit. If you chose to print the form and fill them by hand, please use black ink pen.

- **PLEASE BRING YOUR HEALTH INSURANCE CARD WITH YOU.** We cannot serve you without your insurance card.

- Please try to arrive 10 minutes before your appointment time so we can review you information and prepare your chart

- If your insurance requires referral from your Primary Care Provider, you are responsible for obtaining this referral.

- Not sure if you need a referral? Check with your insurance company or your primary care provider.

- Co-Pays and other applicable payments are due at the time of visit.

- If you do not have health insurance or we do not participate in your plan, you will be responsible for your payment. **We accept Visa and MasterCard.**

- If you need to **cancel the appointment,** please give us **at lease 24 hour notice** as we have set aside a full hour for your visit. **There will be a charge of $50.00 for “no show”. Please note that you will be responsible for this charge. It is not covered by your insurance.**

- This website explains what you can expect from your appointment. If you still have questions, feel free to call us.

ASHA GUPTA MD — PATIENT INFORMATION

Please Print Legibly & Answer All Applicable Questions

Information About the Patient

Name____ Date of Birth ____/ ____ / ____
Last name first name middle initial

Address____
Street or PO Box city state zip code

Home Phone _______________Mobil Phone_____________Other Phone(family etc.)_____________

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Domestic Partner

Occupation __________________ Employer________________ Work Phone________________

Are you a full time college student? ☐Yes ☐ No

Primary Care Physician_________________________Referring Physician______________________

Information About the Person Responsible for Payment of Medical Bills of the Patient

Name______________________ Relation to Patient______________ Date of Birth____/ ____ / ____

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Address if different from patient's address city state zip code

Employer_______________________________________ Work Phone______________________

Medical Insurance Information

Insurance Company_____________________________ Policy Number_______________________

Subscriber's Name_________________Relation to patient____________ Date of Birth____/ ____ / ____
(Name of the person who carries the insurance)

Additional / Secondary Insurance Company_____________________Policy Number_______________

Subscriber's Name_________________Relation to Patient____________ Date of Birth____/ ____ / ____

Emergency Contact Information

Name ____Relation___________________________

Home Phone_____________________Work ___________________Mobil____________________

Consent for Payment and for Release of Information

I certify that the information I have provided above is correct. I authorize Dr. Gupta to release my protected medical information to my insurance company, its agencies and/or Medicare, for the purpose of payment or quality assurance in accordance with the HIPPA policy posted in this office. I authorize Dr. Gupta to collect payment from my insurance company. I understand that I am responsible for payment of charges not covered by my insurance.

Signature__________________Print Name if signing for a minor______________ Date____/ ____ / ____

MEDICATION AND ALLERGY LIST

NAME________________________________ DATE______________

Which pharmacy do you use? ________________________________

LIST ALL MEDICATIONS YOU ARE TAKING

MEDICINE NAME **DOSE AND FREQUENCY**

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LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

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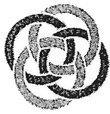

HealthlinkNY Health Information Exchange
LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION: Asha Gupta MD

I understand that I can choose whether to allow the Provider Organization or Health Plan named above to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I get health care. HealthlinkNY is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit the HealthlinkNY website at www.healthlinkny.com.

Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or deny consent may not be the basis for denial of health services. The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills.

Please carefully read the Consent Form Information Sheet about how your information is used before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You can also change your decision at any time by completing a new form.

Please choose only one of the following two options:

☐ **I GIVE CONSENT** for the Provider Organization or Health Plan named above to access ALL of my electronic health information through HealthlinkNY in connection with providing me health care services, including emergency care.

☐ **I DENY CONSENT** for the Provider Organization or Health Plan named above to access my electronic health information through HealthlinkNY for any purpose, ***even in a medical emergency.***

If you want to deny consent for all Provider Organizations and Health Plans participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or calling 844-840-0050.

Printed Name of Patient (Last Name)	(First Name)	Patient Date of Birth (MM / DD / YYYY)

Signature of Patient or Patient's Legal Representative	Relationship of Legal Representative to Patient (if applicable)

Date of Signature (MM / DD / YYYY)	Print Name or Legal Representative (if applicable) Last Name, First Name

HealthlinkNY • (844) 840-0050 • www.healthlinkny.com
49 Court Street, Suite 300 • Binghamton, New York 13901
300 Westage Business Center Drive, Suite 150 • Fishkill, NY 12524