2025
ASTHMA, ALLERGY CARE CENTER OF FLORIDA

Shahnaz Fatteh, M.D.

Board Certified Asthma, Allergy & Immunology: Adult & Pediatrics| Member: AAAAI, ACAAI, FAAIS

Program Director: AAI Fellowship, Nova Southeastern University

www.asthmaallergycare.com

OFFICE POLICIES AND PROCEDURES

Welcome to our practice!

Please visit our website: www.asthmaallergycare.comEmail: fattehoffice@gmail.com

This letter is intended to welcome you and thank you for choosing our practice and to also give you an overview about the guidelines and procedures of our practice. If you have any questions, please feel free to give us a call or ask a staff member. Our telephone number is: (954) 723-0334. Option 1 will transfer you to the Plantation office; option 2 will transfer you to the Pembroke Pines office. Our fax number is: (954) 278-8000. Our goal is to provide quality customer service while meeting your healthcare concerns and needs.

Our practice consists of two offices, one located in Plantation in Central Broward County, the other located in Pembroke Pines in Southwest Broward County. Both offices are available to you to schedule appointments at your convenience. Office hours, doctor availability, and injection hours may change without much notice, please contact the office in advance for more specific and accurate scheduling questions or concerns.

Our medical practitioner, Shahnaz Fatteh, MD is Board Certified Asthma Allergy and Immunology. Throughout the course of your treatment, you may see either Shahnaz Fatteh, MD or one of our other qualified healthcare professionals.

Our office policies are in place to ensure quality and efficient healthcare services and patient care, patient comfort and respect, and to follow guidelines as legislated by HIPAA, the AAAAI, and your insurance company.

- **In regards to patients' allergies, no foods or drinks are allowed in the lobby.**
- **Due to insurance contracts, proper scheduling, and following AAAAI protocol, a new patient cannot be tested on the same day.**
- **Please be respectful and refrain from using cologne, perfume, or lotion in the lobby. Also, prior to the appointment, please keep use of cologne, perfume, or scented lotion to a minimum.**
- **Parents or legal guardians are required to attend all appointments and injection visits for those patients who are 17 years of age and younger, unless there is a letter on file from parent/guardian specifically authorizing visits without them present.**
- **Insurance copayments are due at the time of appointment. Only cash or credit cards are accepted. Cancelled checks are subject to a $25 fee.**
- **Rescheduling or cancelling appointments within 24 hours of appointment are subject to a $25 fee. No shows are also subject to a $25 fee.**

PLEASE SIGN: X _____ PRINT: _____ DATE: _____

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- **Patients are responsible for obtaining their own referrals and providing them to the front office. We can assist with procedure and diagnosis codes if needed.**
- **When placed on allergen immunotherapy, you must call prior to your first injection.**
- **For all future allergy injections, you can simply walk in at your convenience. Please check with the office to verify hours and availability.**
- **When an allergy injection is administered, it is mandatory to wait in the lobby for 30 minutes to ensure that no reaction takes place. When a venom injection is administered, it is mandatory to wait in the lobby for 60 minutes to ensure that no reaction takes place. This is a guideline set forth by the American Academy of Asthma, Allergy and Immunology.**
- **When on allergen immunotherapy, an office visit is required every 3-4 months to properly assess treatment progress.**
- **An appointment is required to obtain lab results. Due to HIPAA, lab results cannot be discussed over the phone.**
- **A 24-hour notice is required for prescription refill requests. We do not mail prescriptions. An appointment within 6 months is required for a prescription refill. Refill requests are at the determination of the provider.**
- **It is HIPAA and federal policy that we provide medical records within 30 days after the initial request.*As a courtesy to you, our office will strive to provide you with your medical records prior to 30 days after the initial request. The medical records need to be reviewed by a medical professional prior to release. The cost is $1 per page.* *As stated by www.hhs.gov**
- **For your child's coordination of care and proper medical documentation, school form requests will require an office visit. The school form will be reviewed and filled out with you, your child (if age appropriate), and with the physician.**
- **Please be aware that filling out of FMLA and Disability forms are subject to a fee and will take up to 30 days to complete.**

If you have any questions about these policies or need further clarification, please speak with the office staff.

We welcome you to our office and look forward to treating you and your family!

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NEW PATIENT INTAKE

DATE: _____ OFFICE (circle one): PLANTATION PEMBROKE PINES

PATIENT NAME: _____S.S.#:_____D.O.B: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE: _____

SEX: _____ MARITAL STATUS: _____ RACE: _____

ETHNICITY: _____ PREFERRED LANGUAGE: _____

E-MAIL: _____ FAX: _____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

PHARMACY NAME: _____

ADDRESS: _____ **PHONE:** _____

CURRENT MEDICATIONS: _____

_____

_____

DRUG ALLERGIES: _____ **SMOKING STATUS:** _____

CHIEF COMPLAINT / CURRENT SYMPTOMS: _____

_____

HAVE YOU EVER BEEN ALLERGY TESTED? _____ WHEN WAS THE LAST TIME YOU WERE TESTED? _____

DO YOU SMOKE? _____ HOW MUCH PER DAY? _____

I (PATIENT) ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE OFFICE POLICIES AND PROCEDURES:

PATIENT SIGNATURE: _____ DATE: _____

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FINANCIAL AGREEMENT

I, _____ understand that my insurance has not guaranteed benefits and has only given an estimate of benefits. I understand that I will be financially responsible for the following: (a) deductibles, (b) coinsurance, (c) copayments and/or any other fees applied by my insurance company per my contract. These fees will be due at the time of visit. I understand that if I do not agree with how benefits were processed on a claim(s) that I should contact my insurance company directly. It is my responsibility to obtain any referrals per my insurance contract and to update Asthma, Allergy Care Center of Florida of any changes (i.e. new insurance, new cards, change of demographical information). Failure to inform the office of any changes may result in additional financial responsibility on my part.

Per verification of benefits, I could be responsible for: (to be filled out by office staff)

Annual Deductible of: _____ *Office Visit Copayment/Coinsurance:* _____

Vials Copayment/Coinsurance: _____ *Injection Copayment/Coinsurance:* _____

If you need to cancel or reschedule an appointment, as a courtesy, we ask you to do so at least 24 hours in advance during normal business hours.

I the undersigned, agree that on this day, I will provide Asthma, Allergy Care Center of Florida with the correct insurance information for billing purposes. I also agree that, if my insurance company denies payment of said claim, then I am totally responsible for the claim on this said date(s) of service. I agree that if the claim is not paid within 30 days of notification or other arrangements have not been made ahead of time, there will be a 2% penalty. If said claim(s) lapse to 60 days, it will go into the hands of a collection agency where fees will be assessed to my account. I also agree that if attorney fees for delinquent accounts arise, I will be responsible for those said fees.

Deductible: A specified amount of money that the insured must pay before an insurance company will pay a claim.
Coinsurance: A percentage that the insured will be responsible for when insurance makes payment to a claim.
Copay: An upfront payment made by the insured at the time of medical services. All bills and balances are to be paid in full and is the sole responsibility of the individual. Bills that are not paid may be sent to collections.

Signature: _____ Date: _____

Insurance: _____ Member ID: _____

Effective Date: _____ Group Number: _____

Employer: _____ Policy Holder: _____

Relationship to Patient: _____ Policy Holder D.O.B.: _____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE INFORMATION (HIPAA)

I acknowledge that I was provided with a copy of Asthma, Allergy Care Center of Florida's Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Asthma, Allergy Care Center of Florida continues its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully, I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office at (954) 723-0334.

I acknowledge that I have received a copy of Asthma, Allergy Care Center of Florida's Notice of Privacy Practices.

Patient Name (Please Print): _____ Date: _____

Patient Signature: _____ Date: _____

Patient Legal Representative (If Applicable): _____

Signature of Legal Representative: _____ Date: _____

Dr. Fatteh and her staff may discuss my medical history, case, and financial arrangements and responsibilities with the following person(s): (NAME – RELATIONSHIP)

1. _____
2. _____

Office staff member obtaining signature: _____

Date: _____

Reason signature was not obtained:

_____*individual refused to sign*
_____*communication barriers prohibited obtaining the acknowledgement*
_____*an emergency situation prevented us from obtaining acknowledgement*
_____*other (specify):* _____

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MEDICAL RECORDS RELEASE AUTHORIZATION

Date: _____

Patient Name: _____ Date of Birth: _____

_____I HEREBY AUTHORIZE YOU TO RELEASE MY RECORDS TO:

_____I HEREBY REQUEST MEDICAL RECORDS FROM:

- ❑ Myself

Physician or Hospital Name: _____

Address: _____

City: _____ Zip Code: _____

Phone #: _____ Fax #: _____

PLEASE RELEASE THE FOLLOWING:

- ❑ Complete medical record
- ❑ Labs & radiology reports
- ❑ Injection contents, antigen concentrations, and dosage schedule
- ❑ History and summary of care

REASON FOR REQUEST:

_____

_____

*Per U.S. Department of Health & Human Services, Office for Civil Rights (www.hhs.gov/ocr/privacy/index.html) a provider has up to 30-days to provide medical records from date of request. You may also have to pay for the cost of copying and mailing if you request copies and mailing. While we have 30 days to complete your request, our practice will do our best to complete your request as soon as possible.

PATIENT SIGNATURE: _____

LEGAL REPRESENTATIVE'S SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

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DIRECTIONS TO THE PLANTATION OFFICE

817 South University Dr. Ste 106, Plantation, FL 33324

From I-95: Take I-595 west and exit at Pine Island Rd. Turn right (north) at Pine Island Rd. Turn right (east) at SW 6 Ct. At the first stop sign, turn right (south) pass by Midtown 24 and make an immediate left (east). We are in the building on the right opposite from a large open grass area.

From I-75/Sawgrass Expressway: Take I-595 east and exit at Pine Island Rd. Turn left (north) at Pine Island Rd. Turn right (east) at SW 6 Ct. At the first stop sign, turn right (south) pass by Midtown 24 and make an immediate left (east). We are in the building on the right opposite from a large open grass area.

From Florida Turnpike: Take I-595 west and exit at Pine Island Rd. Turn right (north) at Pine Island Rd. Turn right (east) at SW 6 Ct. At the first stop sign, turn right (south) pass by Midtown 24 and make an immediate left (east). We are in the building on the right opposite from a large open grass area.

DIRECTIONS TO THE PEMBROKE PINES OFFICE

18503 Pines Blvd. Suite 207, Pembroke Pines, FL 33029

From I-595: Take I-75 south and exit at Pines Blvd. Turn right (west) at Pines Blvd. After passing 184th Ave., immediately after McDonalds turn right (north) into the Atria Medical Plaza. Drive around the lake and back towards the second building at the rear of the complex.

From Palmetto Expressway: Take I-75 north and exit at Pines Blvd. Turn left (west) at Pines Blvd. After passing 184th Ave., immediately after McDonalds turn right (north) into the Atria Medical Plaza. Drive around the lake and back towards the second building at the rear of the complex.

From I-95: Exit at Hollywood Blvd and go west. Hollywood Blvd. turns into Pines Blvd. After passing 184th Ave., immediately after McDonalds turn right (north) into the Atria Medical Plaza. Drive around the lake and back towards the second building at the rear of the complex.

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NAME: _____ DOB: _____ DATE: _____ ID: _____

Thank you for coming to our office today. We need to update information *EACH visit.* Thus we are asking you to complete the following questions, whether the problems. Put a check: _√_ on any problems that you have. If you have no problems in the category, please mark "NO-PROBLEMS" line. If you need assistance with this form, please let us know.

REVIEW OF SYSTEMS QUESTIONNAIRE

Constitutional Systems ☐ **Check here if no problems in this category**

_____Fever _____Chills _____Weight Loss _____Fatigue _____Sweats

Eyes ☐ **Check here if no problems in this category**

_____Change in Vision _____Double Vision _____Itchy Eyes _____Watery Eyes

_____Pain in Eyes _____Dry Eyes _____Discharge from Eyes

Ears, Nose, Mouth, Throat ☐ **Check here if no problems in this category**

_____Ringing in Ears _____Nasal Congestion _____Discharge from Ears _____Pain in Ears

_____Sinus Pain _____Nasal Discharge _____Snoring _____Sore Throat

_____Postnasal Drip _____Hoarseness _____Mouth Breathing _____Nose Bleeds

Allergic / Immunologic ☐ **Check here if no problems in this category**

_____Allergies to Animal Dander (CATS / DOGS / BIRDS) _____Angioedema (SWELLING)

_____Infections requiring antibiotics more than three (3) times a year _____Pneumonia

_____Recurrent Ear Infections _____Recurrent Sinus Infections _____Food Allergies _____Peanut

_____Milk _____Soy _____Fish _____Shellfish _____Tree Nuts _____Other Food

_____Lactose (MILK) Intolerance _____Anaphylaxis _____Eosinophilic Esophagitis _____Food Intolerance

_____Delayed Wound Healing _____Autoimmune Disease _____Lupus _____Rheumatoid Arthritis

_____Thyroid Disease _____Cancer History _____Breast _____Colon _____Leukemia / Lymphoma

_____Other _____Urticaria (HIVES) _____Less than 3 weeks _____more than 3 weeks

Respiratory (LUNGS) ☐ **Check here if no problems in this category**

_____Shortness of Breath _____Wheezing _____Cough with Mucous _____Dry Cough

_____Shortness of Breath with Exercise _____Cough with Blood _____Pain with Deep Breath

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NAME: _____ DATE: _____

Skin ☐ **Check here if no problems in this category**

_____Rash _____Itching _____Bleeding/ Crusting/ Oozing of skin _____Hives _____Hair Loss

_____Rash with Sun Exposure _____Swelling of Skin (Lips/ Eyelids/ Extremities) _____Easy Bruising

_____Thinning of Skin _____Eczema _____Dermatitis

Cardiovascular ☐ **Check here if no problems in this category**

_____Chest Pain _____Skipped Heartbeats _____Palpitations _____Stents

_____Pain in Neck/ Jaw/ Left Shoulder _____History of Heart Attack _____Pacemaker

_____Swelling of legs _____Shortness of breath and walking _____Blood pressure problems

Gastrointestinal ☐ **Check here if no problems in this category**

_____Nausea _____Vomiting _____Constipation _____Diarrhea _____Irritable Bowel Syndrome

_____Colitis _____Reflux/ Heartburn _____Colon/ Stomach Cancer

_____Bleeding _____Stomach/ Peptic Ulcer _____Abdominal Pain

Musculoskeletal ☐ **Check here if no problems in this category**

_____Pain in Joints Where? _____

_____Swelling of Joints Where? _____

_____Osteoarthritis _____Pain in Calves _____Back Pain _____Joint Stiffness

Neurological ☐ **Check here if no problems in this category**

_____Seizure history _____Dizziness _____Light headedness _____Stroke _____Headache

_____Gait Abnormality _____Difficulty Speaking _____Numbness in Arms, Legs, Face

Endocrine ☐ **Check here if no problems in this category**

_____Diabetes _____Increased Thirst _____Frequent Urination _____Weight Gain _____Weight Loss

_____Hot/Cold Intolerance _____Enlarged Thyroid _____Thyroid Nodules

Hematologic/ lymphatic ☐ **Check here if no problems in this category**

_____Enlarged Lymph Nodes _____Easy Bruising _____Enlarged Spleen _____Easy bleeding

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Thank you for coming to our practice. Please fill out the information below so that we can keep accurate records. If you need help with any of the questions, we can assist you once you are in the exam room. Please place a check: _√_ next to your answer.

NAME: _____ DATE: _____

Social History: Adults (If you are a parent with a child, please mark answers for yourself)

_____Single _____Married _____Divorced _____Separated _____Partnership

_____Never Smoked _____Current Smoker _____No Drug Use _____Current Drug Use

_____If Working: Job: _____

Current or Recent Medications used for Patient to be Examined:

	Name of Medication	Dose	Frequency of use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Home Environment:

Home: Apt: _____ Condo: _____ Single Family Home: _____ Trailer: _____

Bedrooms: Carpeting: _____ Tile: _____ Wood: _____ Stone: _____ Laminate: _____

Ceiling Fans: _____ Standing Fan: _____ Stuffed Animals: _____ Air Conditioning: _____

Window Units: _____ Central A/C: _____ Pets (Cat / Dog / Birds): _____

How often are pets washed or groomed? _____ Live Plants? _____ How often are fans dusted? _____

How often are A/C filters changed? _____ Mold in the home? _____ Current or repaired leaks? _____

Feathers? _____