Dear Patients,

During this unprecedented time, we are taking every precaution we can to keep you and our staff safe and healthy. As part of this initiative, we are asking that patients who may be at higher risk of COVID-19 infection request telemedicine visits rather than in person.

Please review and sign the following prior to your in-office visit.

♦♦

I ________________________________ CONFIRM the following:

☐ I DO NOT HAVE A PENDING COVID-19 TEST

☐ I do not currently have any of the following symptoms which could be representative of COVID-19

-OR- that a physician in the practice has already reviewed my symptoms and requested an in-person consultation:

· Fever

· Dry Cough

· Shortness of Breath

· Loss of Smell or Taste

· Diarrhea

· Sore Throat

☐ I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days.

☐ I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days.

Patient Name: ________________________________

Patient/Guardian Signature: ______________________________

Date: ___________________

MICHAEL PREMATTA, MD TRACY PREMATTA, MD
JUEN KIN, MD SUJAL GHELANI, DO
ADULT AND PEDIATRIC ALLERGY
ASTHMA AND CLINICAL IMMUNOLOGY
WWW.DVALLERGY.COM

400 W TOWNSHIP LINE RD
HAVERTOWN, PA 19083
610-789-1313
FAX 610-789-0655

LANKENAU MEDICAL BLDG
100 E. LANCASTER AVE
SUITE 551 E
WYNNEWOOD, PA 19096
610-896-5600

RIDDLE MEMORIAL HOSPITAL
HEALTH CENTER 2
SUITE 2106
MEDIA, PA 19063
610-566-2126

MAIN LINE HEALTH CENTER
1020 BALTIMORE PIKE
SUITE 220
GLEN MILLS, PA 19342
610-361-8300

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to my medical record. Only this information may be used and/or disclosed pursuant to this authorization.

2. I authorize Dr. Klein and his staff to make the authorized use and/or disclosure of my protected health information.

3. I authorize my insurance company and my physicians to receive my protected health information.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to Dr. Klein. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires if I am no longer a patient of Dr. Klein.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Klein, nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request in order for payment of authorized Medicare or commercial insurance benefits to be made to me or on my behalf to Dr. Klein for any services furnished to me by Dr. Klein.

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).I certified that I have received a copy of the authorization.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Printed Name of Patient /Guardian Relationship to Patient

_____
Name of Patient if different from above

THOMAS E. KLEIN, MD PC
MICHAEL PREMATTA, MD TRACY PREMATTA, MD

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PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Thomas Klein, MD PC on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Thomas Klein, MD PC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Thomas Klein, MD PC . I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

SOCIAL SECURITY #_____

MICHAEL PREMATTA MD
TRACY PREMATTA MD ELIAS AKL MD
FAMILY ASTHMA ALLERGY AND IMMUNOLOGY
WWW.KLEINALLERGY.COM

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400 W TOWNSHIP LINE RD
HAVERTOWN, PA 19083
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Name (Last, First)		**DOB**	**Sex** **M F Neutral**
Street Address (Apartment if applicable)		**City**	**State, Zip code**
Home phone number ( )	**Cell phone number** ( )		**Email address** ( )
Employer			**Work Number**
Referring physician name	**Referring physician Phone Number**		**Referring physician address**
Primary Care Provider (PCP)	**PCP Phone number**		**PCP address**
Pharmacy	**Pharmacy Phone number**		**Pharmacy address**
Emergency contact name	**Emergency contact phone number**		**Emergency contact relationship to patient**
Insurance company name	**Policy #**		**Secondary insurance company if applicable**
	Group #		**Secondary insurance policy #**

Please continue to the following page

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Past Medical History

How did you hear about us?

1. **Family/friend**
2. **Referring doctor**
3. **Internet**
4. **Main Line Today**
5. **Other (please specify)**

Past Surgical History

Medications

Medication	Dose	How many times a day

Family history (please check all that applies)

	Father	Mother	Sibling	Child	Other (specify)
Allergic rhinitis (hay fever)					
Asthma					
Atopic dermatitis (eczema)					

Please continue to the following page

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	Father	Mother	Sibling	Child	Other (specify)
Food allergy					
Autoimmune disease (specify)					
Immunodeficiency					
Other (specify)					

Drug allergy

Drug name	Reaction and date if known

Food allergy

Food	Reaction and date if known

By signing below, I acknowledge that the information I provided is correct to the best of my ability

Patient signature:

Guarantor signature (if other than patient)

Today's date

Thank you choosing our practice to help make you feel better.