

**Victor E. Cohen, M.D.**  
**Allergy    Asthma    Immunology**  
4445 S. Eastern Avenue Suite A  
Las Vegas, Nevada 89119  
(702) 735-1556  
Fax (702) 737-7495

Dear Patient (or Parent):

If you (or your child) now take(s) medication to help control asthma, you do not need to stop these before coming for the initial visit. **Antihistamines which are found in all allergy/sinus medications as well as in most over the counter sleep medications should be avoided for at least 7 days. Some stomach medications (Zantac, Tagamet, and Pepcid) should also be discontinued for 7 days. If you are unsure about a medication you are taking, please call our office.**

**You will spend approximately one hour or longer with me during the initial visit. If the patient is a child, please bring him or her without other children. I would like to be able to give the problem(s) at hand my full and undivided attention.**

I look forward to seeing you.

Sincerely,  
Victor E. Cohen, M.D.

***Bring all medications that you are taking in their original containers***

We request that you notify us at least 24 hours in advance if you will be unable to keep your appointment. Thank you.



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## **OFFICE AND BILLING POLICIES**

1. Co-pays, co-insurance and deductibles are due at the time of service. We accept Visa, MasterCard, Discover and Debit cards.
2. Any balance due must be paid in full unless special arrangements are made. We will be happy to work with you on payment of large balances. There will be a \$25.00 fee on any returned check. If you are unclear about your balance, please contact the office so we can assist you. It is **your responsibility** to contact your insurance if they have not paid, or if you feel they have paid a claim incorrectly.
3. We bill most insurance plans. We will only bill a primary and secondary insurance. If no response is received from your insurance, **you will be responsible** for paying the charges and following up with your insurance company. Upon receipt of the Explanation Of Benefits (EOB) from insurance we will make any adjustments required.
4. You must inform our office **IMMEDIATELY** of any change in your insurance coverage. **We do not know your insurance has changed unless you notify us.** If notification is not given prior to services being rendered, **you will be responsible** for paying any charges incurred and for billing your own insurance. **WE DO NOT BACK-BILL INSURANCE!** We have contractual obligations with insurance companies that require us to bill claims within a certain amount of time. If the claims are not billed in that time frame the insurance will not pay. **WE MUST HAVE YOUR CURRENT INSURANCE INFORMATION ON FILE AT ALL TIMES.**
5. Accounts over 90 days past due and on which no payment has been made within the last 30 days may be sent to an outside agency for collection. You are responsible for paying all fees incurred by this office, the collection agency or attorneys during the collection process. Collection accounts are reportable to credit agencies.
6. Refunds for amounts under \$5.00 will be credited to your account for future services.
7. Prescription refills require a minimum of 24 hours notice. We ask that you call your pharmacy and have them fax us the refill request. Please understand that some prescription refills cannot be given without an office visit due to your medical condition.
8. FMLA processing fees are \$25.00 - \$75.00 depending on format and are not billable to insurance. Please allow 3 days to complete.
9. If you have any questions regarding these policies, please feel free to ask us for assistance.

**I have read the above information and agree to abide by the policies as stated.**

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Signature (of responsible party)

Date

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**ELIGIBILITY WAIVER**

I, \_\_\_\_\_ hereby certify that I am  
Name of patient, member, or guardian

eligible participant under the \_\_\_\_\_ plan as of  
Name of insurance company

\_\_\_\_\_. I understand that if I am not eligible I will be  
Month    Day    Year

financially responsible for all services rendered to me by Dr. Cohen, and I agree to pay in full within 30 days of receiving a claim.

I authorize payment of medical benefits directly to Dr. Victor E. Cohen.

I authorize the release of medical records to any medical professional, hospital or medical care facility, insurance company or plan administrator for the purpose of evaluation, treatment or processing claims. This authorization is valid from the date signed for the duration of treatment.

\_\_\_\_\_

\_\_\_\_\_

Signature of member / guardian

Date

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## PRIVACY NOTICE

**The following notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review the information carefully.**

- Your confidential healthcare information may be released to other healthcare professionals for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the practice receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may **not** be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by the practice to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

- You have the right to restrict the use of your confidential healthcare information. However, the practice may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- \* You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request.
- The practice is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- The practice will abide by the terms of this notice. The practice reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

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**Patient Consent for the Use and Disclosure of Protected Health Information**

With consent, Victor E. Cohen, M.D. may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Victor E. Cohen, MD's 'Notice of Privacy Practices' for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent; Victor E. Cohen, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy practices may be obtained by forwarding a written request to Victor E. Cohen, M.D.'s Privacy Officer at 4445 S. Eastern Ave., Suite A, and Las Vegas, NV 89119.

With my consent, Victor E. Cohen, M.D.'s staff may call my home or other designated location and leave a message on my voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Victor E. Cohen, M.D.'s staff may mail to my home or other designated location any items that assist the practice in carrying out healthcare operations, such as appointment reminder cards, patient statements, insurance information, and letters explaining your account.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Victor E. Cohen, M.D.s' use and disclosure of my Protected Health Information to carry out healthcare operations. I may revoke my consent in writing except to the extent that the practice has a ready made disclosure in reliance upon my prior consent. If I do not sign this consent, Victor E. Cohen, M.D. may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

Print Name

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Patient Name

Date

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**THE FOLLOWING MEDICATIONS SHOULD BE DISCONTINUED SEVEN DAYS PRIOR TO ALLERGY TESTING:**

**ANY COUGH/COLD PREPARATIONS  
ANY ALLERGY MEDICATION (ANTIHISTAMINES)**

**OVER THE COUNTER SLEEPING MEDICATIONS : ALL OVER THE COUNTER SLEEPING MEDICATIONS MUST BE DISCONTINUED  
EXAMPLE ( TYLENOL PM,EXCEDRIN PM,NYTOL,SOMINEX).**

**ANTIHISTAMINES: (THIS IS ALIST OF MANY ANTIHISTAMINES)  
THERE ARE MANY DIFFERENT NAMES FOR STORE BRAND ANTIHISTAMINES.LOOK WITH CAUTION FOR THE WORD ALLERGY OR SINUS ON THE BOX**

**ASTELIN NASAL SPRAY  
ACTIFED  
ALLEGRA  
ALLREST  
ALLERX  
ATARAX  
HYDROXYZINE  
BENADRYL  
CHLORPHENIRAMINE  
CLARITIN,CLARINEX  
CONTAC  
DIMETAPP  
DRISTAN**

**STOMACH MEDICATIONS:**

**AXID  
PEPCID  
TAGAMET  
ZANTAC**

**DRIXORAL  
NALDECON  
PHENERGAN  
RYNATAN  
SINE-AID  
SINEQUAN  
SUDAFED PLUS  
(plain sudafed is ok)  
TAVIST D  
TRIAMINIC  
TYLENOL SINUS  
(plain tylenol ok)  
ZYRTEC**