OCEAN ALLERGY
ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY
WELCOME LETTER

WELCOME TO OUR PRACTICE!

WE ARE LOOKING FORWARD TO MEETING YOU AND ASSISTING WITH YOUR MEDICAL CARE. IN AN EFFORT TO ENSURE AN OPTIMAL APPOINTMENT EXPERIENCE, PLEASE ARRIVE 20 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

PLEASE BEGIN BY GOING TO OUR WEBSITE AT **OCEANALLERGY.COM** AND PRINT AND COMPLETE YOUR REGISTRATION FORMS. IN ADDITION TO YOUR PATIENT REGISTRATION FORMS, PLEASE BE SURE TO BRING WITH YOU:

- PHOTO ID
- INSURANCE CARDS
- LIST OF ALL CURRENT MEDICATIONS
- REFERRAL IF REQUIRED
- LABORATORY/X-RAY RESULTS (WRITTEN REPORTS ONLY)
- PERTINENT MEDICAL RECORDS
- CO-PAY IF APPLICABLE

YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED IF THE ABOVE DOCUMENTATION IS NOT PRESENTED AT THE TIME OF CHECK-IN.

IN THE EVENT THAT ALLERGY TESTING IS PERFORMED, PLEASE REFER TO THE GUIDELINES BELOW:

DO NOT APPLY ANY MOISTURIZERS TO YOUR SKIN ON THE DAY OF YOUR APPOINTMENT.

PLEASE STOP ANTIHISTAMINES 7 DAYS PRIOR TO YOUR VISIT. These include but are not limited to:

BENADRYL (DIPHENHYDRAMINE)	ZYRTEC	XYZAL (LEVOCETIRIZINE)	ASTEPRO (ASTELIN)
CLARITIN (LORATADINE)	CLARINEX (DESLORATADINE)	ALLEGRA (FEXOFENADINE)	ALLERGY EYE DROPS
ZANTAC (RANITIDINE)	ATARAX (HYDROXYZINE	DOXEPIN/ ELAVIL	PEPCID (FAMOTIDINE)
PATADAY / PAZEO	CHLORPHENIRAMINE	PATANOL	CHLOR-TRIMETON
PATANASE			

YOU MAY CONTINUE ALL OTHER MEDICATIONS INCLUDING ANY ASTHMA INHALERS. IF YOU HAVE ANY QUESTIONS REGARDING STOPPING ANY MEDICATIONS, PLEASE CALL OUR OFFICE AND SPEAK WITH A MEMBER OF OUR STAFF.

ALL APPOINTMENTS MUST BE **CONFIRMED OR CANCELLED 24 HOURS** PRIOR TO THE SCHEDULED VISIT. NO SHOW AND APPOINTMENTS THAT HAVE NOT BEEN CANCELLED ARE SUBJECT TO MISSED APPOINTMENT FEES WHICH ARE DUE AT TIME OF SERVICE.

THANK YOU FOR TAKING THE TIME TO PREPARE FOR YOUR VISIT TO OUR OFFICE. WE LOOK FORWARD TO SEEING YOU!

APPOINTMENT DATE: _____ TIME: _____

WITH DR. / NP _____

BRICK OFFICE	1673 ROUTE 88 WEST BRICK NJ 08724	T- (732) 458- 2000	F- (732) 458- 4523
WALL OFFICE	1540 ROUTE 138 WEST BLDG 1 STE 103 WALL NJ 07719	T- (732) 681-8700	F- (732) 749-3737

OCEAN ALLERGY
ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

PATIENT DEMOGRAPHICS FORM

Today's Date_____

Patient Name _____ **Marital Status** ___S___M___W___D

DOB_____/_____/_____ **Age** _____ **Male** ___ **Female** ___ **SSN**: _____

Address _____ **Home Phone** _____

City: _____ **Cell Phone** _____

State _____ **Zip Code** _____ **Work Phone** _____

Email: _____

Primary Care Physician: _____ **Telephone #**_____

Race _____ **Ethnicity**_____ **Preferred Language** _____

Responsible Party if Minor _____

Address: _____ **City**_____ **State** _____ **Zip Code**_____

Employer: _____ **Occupation**_____ **Tele#**_____

INSURANCE INFORMATION PLEASE PRESENT ALL INSURANCE CARDS

Primary Ins Co._____ **ID#:**_____ **Group#**_____

Subscriber: _____ **SSN**: _____ **DOB**: _____

Relationship to patient: _____

Secondary Ins Co. _____ **ID#** _____ **Group#** _____

Subscriber: _____ **SSN**: _____ **DOB**: _____

Relationship to Patient: _____

EMERGENCY CONTACT

Name: _____ **Telephone**: _____

I certify that the information I have given today is to the best of my ability as complete and accurate as possible. I will notify the doctor/staff of any changes or additions at subsequent visits.

RELEASE OF INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS AND FINANCIAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

PRINT NAME_____ **SIGNATURE**_____ **DATE** _____

OCEAN ALLERGY

ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

INITIAL VISIT QUESTIONNAIRE

Please answer all questions in their entirety. This is part of the medical history and is therefore confidential.

Name _____ Gender male/ female Birthdate _____

Referring Physician: _____ Tele # _____

Please list the major reason(s) for your visit: _____

PHARMACY NAME AND TELEPHONE NUMBER_____

If appropriate, please circle the months the symptoms are most prominent:

Jan Feb March April May June July Aug Sept Oct Nov Dec

PREVIOUS ALLERGY EVALUATION (indicate when and where) _____

TRIGGERS: PLEASE CIRCLE ALL THAT APPLY

DUST	FEATHERS	DOG	CAT	MOLD	FOODS	DRUGS	HUMIDITY	COLD TEMPS
STRONG ODORS	FRAGRANCE	TEMPERATURE CHANGES	WORKPLACE	HOME	FALL	SPRING		

PLEASE LIST ALL OF YOUR MEDICAL CONDITIONS PLEASE LIST ALL OF YOUR SURGERIES

FAMILY HISTORY: (please indicate which family members have allergy/immunology diseases

	MOTHER	FATHER	SIBLINGS	OTHER FAMILY MEMBERS
ENVIRONMENTAL ALLERGIES				
FOOD ALLERGIES				
ECZEMA				
ASTHMA				
RECURRENT INFECTIONS				
IMMUNE DEFICIENCY				

PLEASE LIST ALL DRUG ALLERGIES: _____ _____ _____ _____ _____

PLEASE LIST ALL FOOD ALLERGIES: _____ _____ _____ _____ _____

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS YOU ARE TAKING WITH DOSAGE AND FREQUENCY

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

OCEAN ALLERGY
ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY
INITIAL VISIT QUESTIONNAIRE

SOCIAL HISTORY: (CIRCLE ALL THAT APPLY) **NAME: _____**

SMOKING STATUS:	CURRENT SMOKER	FORMER SMOKER	NEVER SMOKER

HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN A LIFETIME?	YES	NO
DO YOU USE A SMOKELESS TOBACCO PRODUCT?	YES	NO
ARE YOU AT RISK FOR SECOND HAND SMOKE?	YES	NO

CURRENT OCCUPATION _____FORMER OCCUPATION _____

HAVE YOU HAD ANY OCCUPATION WITH ALLERGIC OR TOXIC EXPOSURE? _____

IF YES WHEN AND WHAT WAS THE EXPOSURE? _____

ENVIRONMENTAL HISTORY: (FOR PATIENTS WITH ASTHMA, NASAL ALLERGIES, OR SINUS DISEASE CIRCLE WHERE APPROPRIATE)

HOME:	HOUSE	APARTMENT	CONDO	MOLD/WATER DAMAGE
RUGS:	WALL TO WALL	AREA		
HEATING SYSTEM:	RADIATOR	HOT WATER BASEBOARD	FORCED HOT AIR	OTHER
BEDROOM:	SHARED	SINGLE		
ALLERGY PROOF COVER	PILLOWS	MATTRESS	BOX SPRING	
PETS:	CATS	DOG	OTHER	

REVIEW OF SYSTEMS: (please circle all that apply)

CONSTITUTIONAL:	LOSS OF APPETITE	FEVER	NIGHT SWEATS	RECENT FATIGUE	SYSTEMIC ILLNESS	RECENT WEIGHT GAIN/LOSS
HEAD:	HEAD TRAUMA	HEADACHE				
EYES:	BLURRED VISION	VISUAL CHANGES	ITCHING/TEARING	REDNESS	LIGHT SENSITIVITY	PAIN
ENT:	HEARING LOSS	BLOODY NOSE	SINUS CONGESTION	DIFFICULTY SWALLOWING		
RESIRATORY:	COUGHING BLOOD	WHEEZING	COUGHING	SPUTUM PRODUCTION	SHORTNESS OF BREATH	
CARDIOVASCULAR:	CHEST PAIN	RAPID OR IRREGULAR HEARTBEAT	DIFFICULTY BREATHING WHEN LYING DOWN	SHORTNESS OF BREATH AWAKENING FROM SLEEP	LOWER EXTREMITY SWELLING	
GASTROINTESTINAL:	NAUSEA	VOMITING	ABDOMINAL PAIN	CHANGE IN BOWEL HABITS		
SKIN:	RASHES	SKIN ULCERS	HIVES	ITCHINESS		
NEUROLOGICAL:	DIZZINESS	HEADACHE	SYNCOPE	WEAKNESS		
ENDOCRINE:	HYPO-GLYCEMIA	EXCESSIVE THIRST	EXCESSIVE URINATION			
HEMATOLOGIC/LYMPHATIC:	EASY BRUISING	BLEEDING	CLOTTING DISORDER	CALF PAIN		
ALLERGY/IMMUNOLOGY:	SEASONAL ALLERGIES	FOOD ALLERGIES	DRUG ALLERGIES			
GENERALIZED PAIN:	YES	NO				

OCEAN ALLERGY

ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

FINANCIAL POLICY

We are pleased you have chosen us as your providers. We appreciate your trust and our goal is to provide you and your family the highest quality of medical care.

Our practice is contracted with numerous insurance carriers. Policies can change and subscribers need to know their own plans benefits and financial responsibilities, such as deductibles, co-pays, and co-insurances.

Your insurance may require a **referral** from your Primary Care Physician to be seen by a specialist, this must be obtained at least 72 hours prior to your visit. Please check with your Primary Care Physician to confirm it has been issued. **We will not be able to see you without a referral and your appointment will need to be re-scheduled.**

Should you choose to be seen in our practice and we do not participate with your insurance plan, you are responsible for the full payment of you bill at the time of service. We will provide you with an itemized receipt so you may file for reimbursement.

Dependent Minors of Divorced Parents: We expect payment from the parent/guardian who accompanies the child to our office. We will not bill a non-custodial parent, even though this may be part of the divorce agreement. We will be pleased to provide a paid receipt for services rendered.

We reserve the right to charge for missed appointments or any appointments **not cancelled 24 hours prior to the scheduled appointment.**

Past due balances are expected to be paid in full before future appointments are made. You agree to reimburse the fees of any collection agency which may be based on a percentage at a maximum of 50% of the debt, and all costs and expenses including reasonable attorney fees we incur in such collection efforts.

Our office accepts **Cash, Check, Visa, Mastercard, and Discover** for your convenience.

I have read and understand the financial policy stated above and authorize payment of any insurance benefits for unpaid services to Ocean Allergy Partners LLC and understand that I am responsible for any balances or unpaid insurance claims and other fees as described. I authorize the release by Ocean Allergy Partners LLC of my medical information that is necessary to evaluate and pay my medical insurance claims.

Print Patient Name _____

Patient Signature_____ Date: _____

Patient Representative's Name _____ Relationship to patient_____

Patient Representative Signature _____

OCEAN ALLERGY
ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

HIPAA RELEASE FORM

NAME: _____ DATE OF BIRTH ____/____/_____

RELEASE OF INFORMATION

_____I authorize the release of information including claims information, diagnosis, and examination records rendered to me.

The information may be release to:

Spouse_____

Children _____

Parent _____

Other _____

_____ Information is NOT to be released to anyone.

The release of Information will remain in effect until terminated by me in writing.

I further agree that the practice may disclose health information to me in the following manner:

Home # _____ Cell # _____ Other_____

If you are unable to reach me:

_____ You may leave a detailed message.

_____ Please leave a message asking me to return your call.

I, _____(Patient/Parent of minor child), acknowledge that I have received a copy of Ocean Allergy Partners LLC's notice regarding Privacy of Personal Health Information.

Signed _____ Date: _____

OCEAN ALLERGY

Allergy, Asthma and Clinical Immunology

Notice Regarding Privacy of Personal Health Information

FOR OCEAN ALLERGY PARTNERS LLC (THE PRACTICE)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this notice regarding privacy of personal health information. The notice describes

1- How the practice may use and disclose your protected health information.
2- Your rights to access and control your protected health information in certain circumstances.
3- The practices duties and contract information.

Protected Health Information
"Protect Health Information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present, or future payment for health care.

The Use and Disclosure of Protected Health Information in Treatment, Payment and Health Care Operations.
Your protected health information may be used and disclosed by the practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The practice may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment
The practice may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the practice may coordinate your health care with a third party. For example, the practice may disclose your protected health information to a pharmacy to fulfil a prescription for asthma medication, to an X-Ray facility to order an X-Ray, or to another physician who is administering your allergy shots which we prepared. In addition, the practice may disclose protected health information to other physicians or health care providers for treatment activities of those other providers.

Payment
When needed, the practice will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended treatment or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, the practice may disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, the practice may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations
The practice may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and of offering quality health care services. Health care operations may include:

1- Quality evaluations and improvement activities
2- Employee review activities and training programs.
3- Accreditation, certification, licensing, or credentialing activities.
4- Reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs.
5- Business management and general administrative activities. For instance, the practice may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the practice may disclose your protected health information to another provider or health plan for their health care operations.

Other uses and Disclosures:
As part of treatment, payment and healthcare operations, the practice may also use or disclose your protected health information to:

1- Remind you of an appointment including the leaving of appointment reminder information on your telephone answering machine.
2- To inform you of health-related benefits or services that may be of interest to you.
3- Inform you of potential treatment alternatives or options

Additional Uses and Disclosures Permitted Without Authorization or an Opportunity to Object
In addition to treatment, payment and health care operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

1- When legally required. The practice will comply with any federal, state or local law that requires it to disclose your protected health information.
2- When there are risks to public health. The practice may disclose your protected health information for public health purposes, including to, as permitted or required by law.
a- Prevent, control, or report disease, injury or disability
b- Report vital events such as birth, or death
c- Conduct public health surveillance, investigations and interventions
d- Collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements and conduct post marketing surveillance
e- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease
f- Report to an employer information about an individual who is a member of the workforce.

To report abuse, Neglect or domestic violence. As required by law or with the patient's agreement, the practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect or domestic violence. To conduct health oversight activities, the practice may disclose your protected health information to a health oversight agency for use in audits, civil administrative, or criminal investigations. Proceedings or actions, inspections, licensure or disciplinary actions or other necessary oversight activities as permitted by law. If you are the subject of an investigation, the practice will not disclose protected health information that is not directly related to your receipt of health care or public benefits, for judicial and administrative proceedings. The practice may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by such order or a signed authorization is provided. For law enforcement purpose's the practice may disclose your protected health information to a law enforcement official for law enforcement purposes when:

1- Required by law to report of certain types of physical injuries
2- Required by court order, court ordered warrant, subpoena, summons or similar process.
3- Needed to identify or locate a suspect, fugitive, material witness or missing person
4- Needed to report a crime in an emergency situation
5- You are the victim of a crime in specific limited instances
6- Your death is suspected by the practice to be the result of criminal conduct.

To coroners, Funeral Directors and for organ donation. The practice may disclose protected health information to a coroner or medical examiner for the purpose of identification, determination of cause of death, or performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the practice may disclose protected health information, including when death is reasonably anticipated, to a funeral director to enable the funeral director to carry out his or her duties. Protected health information may also be used and disclosed for the purpose of cadaveric organ, eye, or tissue donation. To prevent or diminish a serious and imminent threat to health or safety. If in good faith the practice believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to your health or safety or to the health and safety of the public, the practice may use or disclose your protected health information as permitted under law and consistent with ethical standards of conduct. For specified government functions, as authorized by the HIPAA privacy regulations, the practice may use or disclose your protected health information to facilitate specified government functions relating to military and veterans' activities, national security and intelligence activities, protective services for the president and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations. For workers compensation. The practice may disclose your protected health information to comply with workers compensation laws or similar programs.

Uses and disclosures permitted with an opportunity to object.
Subject to your objection, the practice may disclose your protected health information

1- To a family member or close personal friend if the disclosure is directly relevant to the persons involvement in your care or payment related to your care.
2- When attempting to locate or notify family members or others involved in your care to inform them of your location, condition or death. The practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not object to these disclosures, the practice is able to infer from the circumstances that you do not object, or the practice determines, in its professional judgement, that it is in your best interests for the practice to disclose information that is directly relevant to the persons involvement with your care, then the practice may disclose your protected health information. If you are incapacitated or in an emergency situation, the practice may exercise its professional judgement to determine if the disclosure is in your best interests and, if such a determination is made, may only disclose information directly to your health care.

Uses and Disclosures Authorized by You:
Other than the circumstances described above, the practice will not disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

Your Rights:
You have the certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:
The right to inspect and copy your protected health information. For as long as the practice holds your protected health information, you may inspect and obtain a copy of such information included in a designated record set. A" designated record set" contains medical and billing records as well as any other records that your physician and the practice use to make decisions regarding the services provided to you. The practice may deny your request to inspect or copy your protected health information if they if the practice determines in its professional judgment that the access requested is likely to endanger your life or the safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.
In addition, you may not inspect or copy certain records by law, including:

1- Information compiled in reasonable anticipation of, or for use in, a civil criminal, or administrative action or proceeding.
2- Protected health information that is subject to a law that prohibits access to protected health information. You may have the right to have a decision to deny access reviewed in some situations. You must submit a written request to the practices privacy officer to inspect and copy your health information. The practice may charge you a fee for the costs of copying, mailing, or other costs incurred by the practice in complying with your request. Please contact our privacy officer if you have questions about access to your medical record at the number given on the last pages of this notice.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the practice not use or disclose specific sections of your protected health information for the purposes of treatment, payment or

health care operations. Additionally, you may request that the practice not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the practice's privacy officer. The practice may choose to deny your request for a restriction, in which case the practice will notify you of its decision. Once the practice agrees to the requested restriction, the practice may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The practice may terminate the agreement to a restriction in some instances.

The right to request to receive confidential communications from the practice by alternative means or at an alternative location. You have the right to request that the practice communicates with you through alternative means or at an alternative location. The practice will make every effort to comply with reasonable requests. However, the practice may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the practices Privacy officer.

The right to request an amendment of your protected health information.
During the time that the practice holds your protected health information, you may request an amendment of your information in a designated record set. The practice may deny your request in some instances. However, should the practice deny your request for amendment, you have the right to file a statement of disagreement with the practice. In turn, the practice may develop a rebuttal to your statement. If it does so, the practice will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the practices Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures.
You have the right to request an accounting of the practices disclosures of your protected health information made for the purposes other than treatment, payment or health care operations as described in this notice. The practice is not required to account for disclosures:

1- Which you requested
2- Which you authorized by signing an authorization form
3- For a facility directory
4- To friends or family members involved in your care
5- Certain other disclosures the practice is permitted to make without your authorization.

The request for an accounting must be made in writing to our Privacy Officer and should state the time period for which you wish the accounting to include up to a six-year period. The practice is not required to provide an accounting you request of any twelve-month period. Subsequent accountings may require a fee based on the practice's reasonable costs for compliance of the request.

The right to obtain a paper copy of this notice. The practice will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

The Practices Duties
The practice is required to ensure the privacy of your health information and to provide you with this notice of your rights and the practices duties and procedures regarding your privacy. The practice must abide by the terms of this notice, as may be amended periodically. The practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the practice collects and maintains. If the practice alters its notice the practice will provide a copy of the revised notice through regular mail or in-person contact.

Complaints
If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the practice verbally or in writing. Such complaints should be directed to the practices Privacy Officer. The practice encourages you to relay a concern you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

Contact Person

The practices contact person regarding the practice's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the practice should be directed to the Privacy Officer at the following address:

ATTN: Privacy Officer
Ocean Allergy Partners LLC
1673 Route 88 West
Brick NJ 08724
The Privacy Officer can be reached at 732-458-2000.