Allergy & Asthma Associates

Patient Registration

Please print, complete entirely, and return the day of scheduled appointment.

HIPAA COMPLIANT

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Birthdate (MO/DAY/YR):_____ Age: _____ Sex: Male _____ Female _____

Street: _____

City/State/Zip Code: _____

Home Telephone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____ Social Security Number: _____

Email Address: _____ Phone Number to Receive Text Messages: (_____) _____

Relationship to Responsible Person: Self_____ Husband_____ Wife_____ Dependent_____ Marital Status: S_____ M_____ W_____ D_____

Referring Physician: _____ Telephone: (_____) _____ Date Last Seen: _____

Other physicians(s) who care(s) for you and to whom we may disclose information regarding your care:

_____ Telephone: (_____) _____

BILL TO RESPONSIBLE PARTY

Last Name: _____ First Name: _____ Middle Initial: _____

Street: _____

City/State/Zip Code: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Home Telephone: (_____) _____

PRIMARY INSURANCE

Name of Insurance:

_____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Sex: Male _____ Female _____

Policy Holder's Birthdate (MO/DAY/YR):_____ Policy Holder's Social Security Number: _____

Relationship of Patient to Policy Holder: Self_____ Spouse_____ Dependent_____

SECONDARY INSURANCE

Name of Insurance:

_____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Sex: Male _____ Female _____

Policy Holder's Birthdate (MO/DAY/YR):_____ Policy Holder's Social Security Number: _____

Relationship of Patient to Policy Holder: Self_____ Spouse_____ Dependent_____

Patient and/or Insured Name (Please Print Name): _____

Patient and/or Insured (Signature): _____ Date: _____

Revision Date 4/19

Financial Policy

Please print, complete entirely, and return the day of scheduled appointment.

HIPAA COMPLIANT

PATIENT CONSENT FOR USE AND DISCLOSURE OF MEDICAL INFORMATION TO CARRY OUT TREATMENT PAYMENT AND HEALTH CARE OPERATIONS

I consent to the release of information regarding services rendered by the Practice to my insurance company or any governmental payer for my medical expenses or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of medical information to my family physician and other treating physicians, that I designate, as well as to any physicians to whom the Practice may refer me for purposes of further treatment. I also consent to the use and/or release of medical information about me for purposes of health care operations, including quality assurance activities or other activities to review the Practice's treatment and services and to evaluate the performance of the staff in caring for me. In addition, if the patient is a minor, I as parent or guardian, consent to the release of medical information to the child's other parent or the person(s) that I have listed as being responsible for the medical bill. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including, but not limited to, electronic mail (email) and facsimile.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that the Practice has taken action in reliance upon my consent.

PAYMENT AGREEMENT

Regardless of insurance benefits or the designation of some other responsible party listed, I understand that I am financially responsible for all fees. Although the Practice will take reasonable steps to obtain reimbursement from the insurance company or the persons listed on the Patient Registration Form as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financially responsible party. Further, in the event of payment default I agree to pay all collection costs in excess of the initial fee (including any legal expenses) and at the option of the Practice, a reasonable charge for late payment.

At the time of the visit, I understand it is my responsibility to obtain a current referral (if required), or prior insurance authorization prior to services, and pay any deductibles, co-payments, and/or coinsurance not covered by the insurance plan or a governmental program. Further, I authorize to file claims on my behalf for covered services and assign all insurance or other payer benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original. For missed appointments, there is a $25.00 fee unless the appointment has been cancelled at least 24 hours in advance.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

Patient and/or Insured Name (Please Print Name): _____

Patient and/or Insured (Signature): _____ Date: _____

Notice of Rights and Responsibilities

Please print, complete entirely, and return the day of scheduled appointment.

HIPAA COMPLIANT

Our pledge regarding your medical information:

We understand that your medical information is personal. We are committed to protecting medical information about you. We create a record of your care to provide you with quality of care and to comply with certain legal requirements. This notice applies to all records of your care generated by each of our health care delivery sites, whether made by our employees or our physicians.

This notice describes the ways in which we may use and disclose medical information about you. Disclosure means the release, transfer, or provision of or access to Protected Health information (PHI). This Notice of Privacy Practices also describes your rights, your obligations, and our obligations regarding the use and disclosure of your medical information.

PATIENT RIGHTS

The following list of rights and responsibilities does not presume to be all-inclusive, but is intended to show our concern for you and to emphasize the need for observance of these rights and responsibilities. For specific inquires or further details concerning your rights the practice manager will be available for assistance.

Although your health record is the physical property of Allergy & Asthma Associates, the information belongs to you. You have the following rights:

1. Right to access and copy your record. Ohio Revised Code Rates will be used for copying fees.
2. Right to amend or make changes to your record. A meeting must be scheduled with the Managing Physician to discuss amendments/changes.
3. Right to an accounting of disclosures.
4. Right that we do not disclose health information about you (also called restrictions).
5. Right to receive confidential communications.
6. Right to receive a copy of this notice at any time.
7. Right to be treated considerate and respectful in a safe environment, free from all forms of abuse, harassment, or discrimination.
8. Right to participate in the development of your treatment plan of care, including the right to request/and or refuse care.
9. Right to be informed about possible risk/ benefits to of ongoing care.
10. Right to remain free of seclusion or restraints of any form that is not medically necessary.
11. Right to expect your medical record is confidential and information will not be disclosed unless you have given written permission with the exception of Treatment Payment and Healthcare Operations as allowed by law.
12. Right to request an interpreter or translator.

PATIENT RESPONSIBITIES

1. Arrive to appointment on time.
2. Notify the medical clinic if you are unable to keep appointment at least 24 hours in advance.
3. Report any medical conditions that will assist medical personnel with your treatment.
4. Be courteous, considerate, and respectful of other patients and staff.
5. Provide safekeeping of own possessions (cell phone, clothing, money, etc.) while at the clinic.
6. Ask question(s) when you do not understand information being provided to you.
7. Be responsible for assisting in the control of noise while in the office.
8. Meet financial obligations regarding your healthcare as promptly as possible.
9. Follow physician orders in accordance with your individual treatment plan.
10. Notify your physician of any changes or problems with your medical treatment.
11. Notify Practice of any demographic, billing, or insurance change.

Should you believe your rights have been violated, you may contact our Privacy Officer at (937) 431-0721 to request a Patient Grievance Form. This form must be completed and sent to Allergy & Asthma Associates, attention: Privacy Officer. Once reviewed, the Privacy Officer will contact you with further instructions. Should your grievance not be resolved, the Privacy Officer can provide you with additional instructions for grievance resolution.

I, _____ acknowledge that I have read these Patient Rights and Responsibilities and that I understand them.

Patient and/or Insured Name (Please Print Name): _____

Patient and/or Insured (Signature): _____ Date: _____

Allergy & Asthma Associates

Patient Record of Disclosures

Please print, complete entirely, and return the day of scheduled appointment.

HIPAA COMPLIANT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

Home/Cell Telephone Number: _____

- ❑ O.K. to leave message with detailed information on answering machine or voicemail.
- ❑ O.K. to leave message with detailed information with family member or whomever is available.
- ❑ Leave message with call-back number only.

Work Telephone Number: _____

- ❑ O.K. to leave message with detailed information.
- ❑ Leave message with call-back number only.

Written Communication:

- ❑ O.K. to mail to my home address.
- ❑ O.K. to mail to my work address.

  Work Address:_____

  Work Address City/State/Zip Code:_____
- ❑ O.K. to fax to this number (_____) _____

Patient and/or Insured Name (Please Print Name): _____ Patient's Date of Birth: _____

Patient and/or Insured (Signature): _____ Date: _____

Allergy & Asthma Associates

New Patient History

Please print, complete entirely, and return on the day of your scheduled appointment.

Patient Name:_____ Sex: M F Birthdate: _____ Age: _____

Reason for seeing an Allergist:_____ Patient Occupation:_____

Doctor(s) that should receive a summary letter of today's visit:_____

Circle all symptoms that apply:

Nose:	Nose:	Eyes:	Chest:	Head:	Skin:	Swelling:	Stomach:
stuffy nose	nosebleeds	red eyes	tightness	sinus headaches	hives	lips	nausea
runny nose	mouth breathing	itchy eyes	wheezing	migraine headaches	rash	hands/feet	vomiting
post nasal drip	loss of smell	watery eyes	cough		itchy skin	throat	diarrhea
itchy nose	loss of taste		short of breath			tongue	heartburn
sneezing	snoring					other: _____	

When did allergies initially occur (age or date):_____

Antihistamine use (such as Zyrtec, Claritin or Allegra): none when needed seasonal daily Helpful? Y/N

Nasal steroid use (such as Flonase, Nasonex, or Nasacort): none when needed seasonal daily Helpful? Y/N

List other medications tried (such as Singulair, Sudafed, Afrin, Azelastine):_____ Helpful? Y/N

Symptoms are worse (circle all that apply)

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec year-round awakening morning afternoon evening night outside at work

Suspected triggers based on your observations? (circle all that apply):

cosmetics	trees	strong odors	paint	dusty areas
weather changes	molds	perfume	smoke	dog
grass	cat	weeds	dampness	other:_____

Previous Allergy Testing? Y/N By Dr. _____ in _____(year)

Previously/currently on allergy shots? Y/N for ___ years Shots help? Y/N Bad reactions to shots? Y/N

Ear/nose/throat surgery? Y/N Type/date of surgery:_____

Housing: apartment house Infestation concerns: mice cockroach mold other:_____

Air conditioning: none window central **Heating:** gas electric wood radiator kerosene/oil

Smoking in the home? Y/N Self Family Member:_____ **Daycare** (child)**?** Y/N

Personal Smoking History: Y/N Packs per day:_____for_____years. Quit date:_____

Pets: dogs (#___) inside/outside cats (#___) inside/outside other pets:_____

How long have you lived in Ohio?_____ Previous Residence:_____

Foods/medications that have caused you to *react* (please list trigger and associated symptoms): _____

_____

Please describe any significant reactions to insect stings:_____

Allergy & Asthma Associates

New Patient History

Please print, complete entirely, and return on the day of your scheduled appointment.

Patient Name:_____

Additional Review of Systems (circle all that apply)

fever	heat/cold intolerance	chest pain/palpitations
weight loss	excessive or painful urination	fainting/lightheadedness
abnormal weight gain	excessive thirst	bleeding/clotting problems
mouth or eye sores	frequent infections requiring antibiotics	low blood counts
joint pain/swelling	seizures	depression/anxiety

If you have asthma, wheezing or shortness of breath:

Age at onset:_____ Attacks per year:_____ Lost school/work days (in past year):_____

Number of hospitalizations for breathing troubles:____ Intensive care? Y/N

In the past year *for breathing concerns*, number of trips to the emergency room?___ urgent care?___ doctor's office?___

Daytime breathing symptoms (circle): No Less than 3 days/week 3 or more days/week Daily

Nighttime breathing symptoms (circle): No Less than 3 nights/month 3 or more nights/month Nightly

Rescue inhaler (albuterol) use: No Less than 3 times/week 3 or more times/week Daily

In the past year, how many times have steroids (like prednisone) been needed for breathing issues? _____

Daily medications tried for asthma:_____

What triggers chest symptoms, such as wheezing, shortness of breath? (circle all that apply)

pollens molds animals colds/viral illness exercise other:_____

Family History (circle all that apply)

allergies	asthma	cystic fibrosis	nasal polyps	immune deficiency
emphysema/COPD	food allergy	insect sting allergy	autoimmune disorders	other relevant condition:

_____

Past Medical History:

Circle all that apply: Heart disease High blood pressure Acid reflux disease Thyroid disease

Please list other important current or significant past health conditions: _____

_____

What You Need to Know About Skin Testing…

- To facilitate the efficiency of our business office, we ask that you contact your insurance company to verify if a referral/prior authorization is needed from your primary care doctor/pediatrician. If a referral/prior authorization is required, it is the patient's responsibility to obtain. Also, please bring your insurance ID card at the initial visit with the policy holder's name and date of birth.

- Skin tests will be performed in most instances to determine if and to what you are allergic. Skin testing remains the most rapid, sensitive, and reliable method of making this determination. Ordinarily most tests are done on the arms and only a few tests may be necessary.

- Most tests are performed using a plastic, toothpick-like device making a superficial prick on the skin of the forearm or back. All types of tests are relatively painless.

- Children, especially young children, may be frightened of the tests, and they may seem to "hurt" more than older children or adults. Being honest with them ("the tests may sting and itch like a mosquito bite"), and explaining and demonstrating what is to be done (on the parent if so desired) usually allay such fears.

- Skin testing can usually be accomplished in one visit and will usually last about one hour or less. It is necessary that all antihistamines be stopped five days prior to skin testing. Antihistamines will block the skin test reaction. We also recommend you make arrangements for the care of any young children who are not being evaluated.

- It is ok eat before you come!

Revision Date 9/16

You cannot be skin tested while taking the following medications…
DISCUSS AN ALTERNATIVE WITH YOUR PHYSICIAN

Do not discontinue antidepressants/psychotropic medications without consulting your prescribing physician.

Call your pharmacy or prescribing physician if you are unsure about the names of your medications.

Asthma medications do not affect skin testing. Do not stop your asthma medications!

The following is a partial list of medications that should be discontinued at least 5 days prior to skin testing. Also, most over-the-counter sleep aids and allergy/cold medicines should be avoided. Any medicine listing drowsiness or sedation as a side effect may need to be stopped before testing.

- Actifed®
- Alavert®
- Alka-Seltzer Plus®
- Allegra®
- Allerestl® A.R.M.
- Astelin®
- Astepro®
- Atarax®
- Atrohist®
- Atrohist Plus®
- Benadryl®
- Bromfed®
- Brompheniramine®
- Certirizine
- Chlorpheniramine®
- Chlor-Trimeton®
- Clarinex®
- Claritin®
- Contac®
- Coricidin®
- CTM dexbrompheniramine®
- Cyproheptadine®
- Dallergy®
- Deconamine®
- Dexbrompheniramine®
- Dimenhydrinate®
- Dimetane®
- Dimetapp®
- Diphenhydramine
- Dramamine®
- Drixoral®
- Duratapp®
- Duratapp PD®
- Dymista®
- Fexofenadine
- Hydroxyzine®
- Levocetirizine®
- Loratadine
- Meclizine®
- Naldecon®
- Nyquil®
- Palgic®
- Patanase®
- Periactin®
- Phenergan®
- Poly-Histine®
- Promethazine®
- Pyribenzamine®
- Robitussin CF®
- Rondec®
- Rondec TC®
- R-Tannate®
- Ru-Tuss®
- Rynatan®
- Sudafed Plus®
- Tanafed®
- Tannate®
- Tavist®
- Tavist D®
- Triaminic®
- Trinalin®
- Tripelennamine®
- Triprolidine®
- Vistaril®
- Xyzal®
- Zyrtec®
- Zyrtec D®

The following medications should be discontinued for 7 days prior to skin testing:

- Amitriptyline®
- Doxepin®
- Elavil®
- Imipramine®
- Sinequan®
- Tofranil®

The following medications should be discontinued for 1 day prior to skin testing:

- Axid®
- Benadryl®cream
- Pepcid®
- Tagamet®
- Zantac®

You may take the following medications for nasal congestion:

- Any over-the-counter decongestant or saline spray or Nasalcrom®
- Any steroid allergy spray (Flonase®, Fluticasone®, Nasacort®, Nasarel®, Omnaris®, Rhinocort®, Qnasl®, Zetonna®)
- Any oral decongestant (Entex®, PSE, Guaifed®, Humibid®, Sudafed® (not Sudafed® Plus)

Revision Date 8/15

Allergy & Asthma Associates

Office Locations

Beavercreek
2359 Lakeview Drive
Beavercreek, OH 45431-3695
Phone: (937) 431-0721
Fax: (937) 431-5419

(Located behind Mike's Car Wash)

Huber Heights
8501 Troy Pike, Suite 110
Huber Heights, OH 45424
Phone: (937) 237-5101
Fax: (937) 233-5844

(Located inside the Dayton Children's Building)

Kettering
5250 Far Hills Avenue, Suite 150
Kettering, OH 45429
Phone: (937) 434-4611
Fax: (937) 434-9107

(Located in between the Dover Medical Building and Apex Church)

Springfield
2121 East High Street, Suite C
Springfield, OH 45505
Phone: (937) 323-3585
Fax: (937) 233-5844

(Located across the street from Governor's Place)

Revision Date 5/17