ASTHMA & ALLERGY SPECIALISTS, PA

8045 Providence Rd.
Suite 300
Charlotte, NC 28277
(704) 341-9600
Fax (704) 341-9996

855 Sam Newell Rd.
Suite 206
Matthews, NC 28105
(704) 321-2793
Fax (704) 321-9382

10310 Mallard Creek Rd.
Suite 101A
Charlotte, NC 28262
(704) 503-4888
Fax (704) 503-4488

C. T. Humphries, MD, MBA *William S. Ashe, Jr., MD* *Hugh R. Black, II, MD*
Vandana, K. Patel, MD *Doug T. Johnston, DO*

DATE:_____ EMAIL ADDRESS:_____

PATIENT'S NAME: _____ SOCIAL SECURITY#: _____

ADDRESS_____ TELEPHONE#: _____

_____ CELL PHONE#_____

_____ BIRTHDATE: _____

OTHER MEMBERS OF THE FAMILY THAT ARE PATIENTS HERE: _____

PHARMACY: _____ ADDRESS: _____

PHONE#_____

HISTORY

REASON FOR EVALUATION: _____

CIRCLE MONTHS WHEN SYMPTOMS ARE WORSE: JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

PRESENT MEDICATIONS: _____

_____

_____

HOSPITALIZATIONS (include date and diagnosis): _____

_____

NUMBER OF DAYS OF WORK/SCHOOL MISSED IN THE LAST YEAR DUE TO ILLNESS: _____
(if too young for school, estimate days child would have missed)

FAMILY HISTORY OF:_____ASTHMA _____HAYFEVER _____HIVES _____ECZEMA _____FOOD ALLERGY

IS PATIENT ALLERGIC TO ANY MEDICATIONS? _____

NAME OF MEDICATION: REACTION:

_____ _____

_____ _____

_____ _____

FEMALE PATIENTS, COULD YOU BE PREGNANT? _____YES _____NO

ENVIRONMENTAL SURVEY

AGE OF YOUR RESIDENCE: _____ DOES YOUR HOME HAVE A BASEMENT? _____

TYPE OF HEATING: _____ AIR CONDITIONING (CENTRAL OR WINDOW): _____

FLOOR COVERING: _____ CONTENTS OF PILLOW: _____ AGE OF MATTRESS: _____

ANY PETS? TYPE: _____ INSIDE OR OUTSIDE: _____

TYPE: _____ INSIDE OR OUTSIDE:_____

TYPE: _____ INSIDE OR OUTSIDE:_____

ANY FAMILY MEMBERS WHO SMOKE AT HOME?_____

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Patient Name: _____ ☐ M ☐ F
First Middle Last

DOB: _____ Social Security #: _____ Race: _____

Email Address: _____ Language Spoken: _____

Address: _____

City/State/Zip: _____ Phone #: _____

Patient's Primary Care Doctor: _____
First Last Practice Name

(IF PATIENT IS UNDER 18 YEARS OF AGE)

Mother's Name: _____ Social Security #: _____

DOB: _____ Employer: _____ Work Phone #: _____

Father's Name: _____ Social Security #: _____

DOB: _____ Employer: _____ Work Phone #: _____

(IF PATIENT IS MARRIED)

Spouse's Name: _____ Social Security #: _____

DOB: _____ Employer: _____ Work Phone #: _____

INSURANCE INFORMATION

#1 (Primary) Insurance Co. Name: _____

Ins. Begin Date: _____ ID #: _____ Group #: _____

Employer: _____

Insured/Employee: _____ Relationship To Patient: _____

#2 (Secondary) Insurance Co. Name: _____

Ins. Begin Date: _____ ID #: _____ Group #: _____

Employer: _____

Insured/Employee: _____ Relationship To Patient: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Asthma & Allergy Specialists, P.A. to release pertinent medical information to insurance carriers. Additionally, I authorize my insurance benefits to be paid directly to Asthma & Allergy Specialists, P.A., realizing I am responsible to pay all non-covered services.

Signature: _____ Date: _____
(Patient, Parent, or Guardian)

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FINANCIAL POLICY

We would like to thank you for choosing our practice to take care of you or your child's medical needs. We are committed to providing the best possible medical care. The following statements and information are provided to avoid any confusion regarding payment for professional medical services.

1. Payment is due at the time of service. This includes any copay, coinsurance or deductible amounts. If you have not met your deductible, a minimum payment of 50% for charges for that date of service is required at the time of visit. Your insurance will be filed as a courtesy. Any remaining balance will be sent to you in a statement. Payment is due within 30 days.

2. If you feel that you may be unable to pay for the services in full at the time of service, you must arrange a payment plan with our business office prior to the visit.

3. If your insurance requires that you obtain a referral from you Primary Care Physician before receiving services in our office, it is your responsibility to bring the necessary authorization with you. Additionally, you should understand the limits of your authorization including the type of treatment authorized, the number of visits allowed, and the expiration date of your authorization.

4. We accept cash, check, debit card, Visa, Mastercard, Discover and American Express.

5. A $25 fee will be applied to your account for any cancelled or rescheduled appointment with less than 24 hours notice and for any no show appointments.

6. You, the patient, have a contract with your insurance company. Any charges not covered by your insurance company are your responsibility.

Acknowledgment and Authorization

I have read, understand and agree to the above policies. I understand the charges not covered by my insurance company, as well as copays, coinsurance and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to Asthma & Allergy Specialists, P.A.

I authorize Asthma & Allergy Specialists, P.A., to release any medical records or other information to my insurance company when requested.

Patient Name:_____ Date of Birth:_____

Signature: _____ Date: _____

Witness: _____

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HIPAA ACKNOWLEDGMENT AND CONSENT

A copy of Asthma & Allergy Specialists, P.A. Notice of Privacy Practices, has been made available to me, version effective September 23, 2013. I consent to the uses and disclosures of the patient's protected health information as outlined in the Notice.

_____ _____
Print Patient Name and Date of Birth Today's Date

_____ _____
Signature of Patient/Representative Relationship of Representative to Patient

Please list names and relationship of **ALL** parties that are authorized to discuss the above listed patient's PHI (Protected Health Information). Anyone other than a parent or legal guardian will not be able to access any information if they are not listed below.

☐ Spouse_____ ☐ Other_____
Name Name/Relationship

☐ Son/Daughter_____ ☐ Other_____
Name Name/Relationship

☐ Parent_____ ☐ Other_____
Name Name/Relationship

I may be contacted in the following ways (please check all that apply):

	OK to leave detailed information	Name, Practice and call back number only
☐ Home_____	☐	☐
☐ Cell _____	☐	☐
☐ Work_____	☐	☐
☐ Email_____	☐	☐
☐ Other_____	☐	☐

FOR OFFICE USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

Employee Signature_____ Date _____

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INFORMATION FOR YOUR APPOINTMENT

1. You must not take any antihistamines for 5 days prior to your appointment (see list below).
2. Due to our testing procedures, if you are a patient with long hair please bring the necessary clips to tie back your hair.
3. Your first appointment may take up to 2 hours.
4. We ask that you not mail the patient registration forms. Please bring the completed forms with you to your visit.
5. If you are covered by Medicaid, you must bring your Medicaid identification card(s) in order to be seen the day of your appointment.
6. It is our courtesy to file your insurance. Please bring your insurance identification card(s).
7. Any portion that is not covered by your insurance (copay, coinsurance, or deductible) is due at the time of service.
8. If you are covered by an insurance plan that requires an authorization in order for you to be seen by a specialist, please contact your primary care physician prior to your appointment for authorization. You primary care physician may fax your records and/or authorization to: (704) 341-9996.
9. Bring a complete list of ALL current medications.
10. If possible, please bring a copy of any medical records pertinent to your visit with us.

ANTIHISTAMINES:

(If you are unsure if your medication contains antihistamine, please consult your pharmacist).

Allegra (Fexofenadine)
Antivert or Bonine (Meclizine)
Astelin or Astepro (dispensed as Nose Spray)
Atarax (Hydroxyzine)
Benadryl (Diphenhydramine)
Bromfed (Brompheneramine)
Chlortrimeton (Chlorpheniramine)
Claritin (Loratidine)
Clarinex (Desloratadine)
Dramamine (Dimenhydrinate)
Dymista
Pataday or Patanase (dispensed as eye drop)
Periactin (Cyproheptadine)
Phenergan (Promethazine)
Semprex (Acrivastine)
Tavist (Clemastine)
Unisom (Doxylamine)
Zyrtec (Cetirizine)
Zantac, Pepcid, Axid, Tagamet (H2 Blockers)
Xyzal

ANTIHISTAMINE/DECONGESTANT COMBINATION MEDICATIONS:

Allergra D
Bromfed DM
Claritin D
Clarinex D
D Allergy
Rynatan
Semprex D
Tavist D
Tussicaps
Tussionex