Asthma & Allergy Specialists, PA

C. Thomas Humphries, MD, MBA *William S. Ashe, Jr., MD* *Hugh R. Black, II, MD* *Vandana K. Patel, MD, FAAAAI*

Douglas T. Johnston, DO, FAAAAI *Jennifer L. Caicedo, MD, FAAP* *Raquel Z. Durban, MS, RD, LDN*

8045 Providence Rd.
Suite 300
Charlotte, NC 28277

855 Sam Newell Rd.
Suite 206
Matthews, NC 28105

10310 Mallard Creek Rd.
Suite 101A
Charlotte, NC 28262

13557 Steelecroft Pkwy.
Suite 2200
Charlotte, NC 28278

3614 Providence Rd. S.
Suite 101
Waxhaw, NC 28173

Ph: (704) 341-9600 Fax: (704) 341-9996

Patient Name: _____ ☐ M ☐ F
First Middle Last

DOB: _____ Social Security #: _____ Preferred Language:_____

Ethnic Group: ☐ Asian ☐ Hispanic/Latino ☐ African American/Black ☐ Caucasian ☐ Not Specified

☐ Native Hawaiian/Other Pacific Islands ☐ American Indian/Alaska Native ☐ Specify Additional Ethnicities:_____

Email Address:_____

Phone (Please check your preferred contact number):

☐ Home:_____ ☐ Cell:_____ ☐Work:_____

Address: _____
City State Zip

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

Pharmacy Name:_____ Phone #:_____ Address:_____

(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 be a part of your healthcare 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 the visit. Your insurance will be filed as a courtesy. Any remaining balance will be sent to you in a mailed 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 your 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.

Acknowledgement 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, coinsurances, 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, PA, to release any medical records or other information to my insurance company when requested.

Patient Name:_____ Date of Birth:_____

Signature:_____Date:_____

Witness *(Asthma & Allergy Specialists Employee)*_____

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HIPAA ACKNOWLEDGEMENT AND CONSENT

A copy of Asthma & Allergy Specialists, PA 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 outlines 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 relationships 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 acknowledgement 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 acknowledgement 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 or email 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) to be seen the day of your appointment.
6. It is our courtesy to file your insurance. Please bring your insurance identification cards(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. Your 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 with your pharmacist)

Allegra (Fexofenadine)
Antivert or Bonine (Meclizine)
Astelin/Astepro (Azelastine) **(Dispensed at Nasal Spray**)
Atarax (Hydroxyzine)
Benadryl (Diphenhydramine)
Banophen (Diphenhydramine)
Bromfed (Brompheneramine)
Chlortrimeton (Chlorpheniramine)
Claritin (Loratadine)
Clarinex (Desloratadine)
Dramamine (Dimenhydrinate)
Dymista **(Dispensed at Nasal Spray**)
Optivar (Azelastine) **(Dispensed as Eye Drop)**
Patanase (Olapatadine) **(Dispensed at Nasal Spray**)
Patanol, Pataday, Pazeo **(Dispensed as Eye Drop)**
Periactin (Cyproheptadine)
Phenergan (Promethazine)
Ryvent (Carbinoxamine)
Semprex (Acrivastine)
Tavist (Clemastine)
Unisom (Doxylamine)
Zyrtec (Cetirizine)
Zantac, Pepcid, Axid, Tagamet **(H2 Blockers)**
Xyzal (Levocetirizine)

ANTIHISTAMINE/DECONGESTANT COMBINATIONS:

Most cold and cough preparations will contain an Antihistamine, carefully read the labels of any medication you or your child are taking prior to your New Patient Appointment. Please consult with your pharmacist if you are unsure.

Allegra D
AlkaSeltzer Plus
Benadryl D
Bromfed DM
Claritin D
Clarinex D
DAllergy
Robitussin DM (Night)
Rynatan
Semprex D
Sudafed PE Day/Night Sinus Congestion
Tavist D
Tussicaps
Tussionex
Zyrtec D

Thank you for choosing Asthma & Allergy Specialists, P.A. for your healthcare needs!