ASTHMA & ALLERGY SPECIALISTS, PA

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

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8045 Providence Rd
Suite 300
Charlotte, NC 28277

10310 Mallard Creek Rd
Suite 101A
Charlotte, NC 28262

13557 Steelecroft Pkwy
Suite 2200
Charlotte, NC 28278

Patient Name: ____ ☐ **M** ☐ **F**
First **Middle** **Last**

DOB: ________________**Preferred Language:**_________________________ **Email Address:**_______________________________

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

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

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 26 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: _______________________________________**Policy/Member ID#**______________________________

Group #: ______________________________ **Insured/Employee:** ___________________________________**Employer:**_________________________

DOB:_______________________ **Relationship to Patient:**_____________________________ **Insurance Begin Date:**___________________________

#2 (Secondary) Insurance Co. Name: _______________________________________**Policy/Member ID#**______________________________

Group #: ______________________________ **Insured/Employee:** ___________________________________**Employer:**_________________________

DOB:_______________________ **Relationship to Patient:**_____________________________ **Insurance Begin Date:**___________________________

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 <u>must</u> 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, Care Credit,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.

<u>Acknowledgement and Authorization</u>

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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Authorization for Release of Information – Compound Release

Name of Patient: ___________________________________ Date of Birth: _______________

Asthma & Allergy Specialists, PA is authorized to release PHI about the above-named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.
☐ Voice Mail	☐ Appointment Reminders
☐ Other person (s) (provide name and phone number) (Example: Spouse, Parent, Relative, Grandparent, Stepparent) ☐ ____________________________________ ☐ ____________________________________ ☐ ____________________________________	☐ Financial ☐ Treatment
☐ Email communication-Provide email address* ______________________________ *For email communication to occur, accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * ______________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: ______________________________

☐ For **text and email communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive text and email communication as selected.

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: ____ Date: ___________

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on ____________________________.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

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Acknowledgement of Receipt

Of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

__________________________________ ______________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ____
- ❑ Other:____ ____

Prepared By ___________________________________

Signature ___________________________________

Date ___________________________________

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.
11. If there is a specific food that you need to be tested, we request that you bring that food with you to your scheduled appointment.

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**)
Midol **Complete** (Pyrilamine Maleate)
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)

Tricyclic Antidepressants (i.e. Doxepin)

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!