Premier Allergy and Asthma Centers

Name: ____

DOB: ____________________ **Date:** ______________________________

MEDICAL AND ALLERGY HISTORY QUESTIONNAIRE

Please answer all questions to your best knowledge **and have your list of current medications available**. If necessary, have your other health care providers send us with information relating to your previous imaging studies, laboratory tests and/or treatments.

CHIEF COMPLAINT(S): ____

____

____

____

New: Chronic: Duration:________________ First onset:______________________

ALL YOUR CURRENT MEDICATIONS (please list ALL medications, supplements taken for any reason):

MEDICATION	DOSE (mg)	?? times / day	Comment

PAST MEDICAL HISTORY:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Malignancy
- ☐ Osteoporosis
- ☐ Reflux
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Other:__________________________________
- ☐ ____________________________________
- ☐ ____________________________________

PAST SURGICAL HISTORY:

- ☐ Ear tubes
- ☐ Sinus surgery
- ☐ Tonsillectomy/adenoidectomy
- ☐ Other:_______________________________
- ☐ ____________________________________

Your preferred pharmacy:

Name:_________________________________

Address:_______________________________

Phone:________________________________

Fax:__________________________________

YOUR CURRENT ALLERGY SYMPTOMS

Nose	
Throat	
Ears	
Eyes	
Sinus	
Breathing	
Skin	
Hives/swelling	
Eczema	
Rashes	
Food reactions	
Insect stings	
Drug reactions	
Other	

FAMILY HISTORY

Relative	Allergies - type	Asthma	Other Illness
Father			
Mother			
Brother(s)			
Sister(s)			

OTHER CURRENT SYMPTOMS:

Constitutional

- ☐ Weight loss
- ☐ Weight gain
- ☐ recurrent fevers and chills
- ☐ night sweats
- ☐ Other______________________________

Cardiovascular

- ☐ irregular heartbeats/palpitations
- ☐ low blood pressure
- ☐ chest pain or burning
- ☐ loss of consciousness (black-outs)
- ☐ high blood pressure

YOUR CURRENT ALLERGY SYMPTOMS

- ☐ angina
- ☐ Other______________________________

Gastrointestinal

- ☐ Heartburns/reflux
- ☐ bloating
- ☐ abdominal pain
- ☐ vomiting or diarrhea
- ☐ constipation
- ☐ irritable bowel
- ☐ Other_______________________________

Genitourinary

- ☐ painful urination
- ☐ frequent urination
- ☐ blood in urine
- ☐ kidney stones
- ☐ urinary infections
- ☐ Other______________________________

Musculoskeletal

- ☐ Muscle pains/aches
- ☐ Cramping
- ☐ Joint pains
- ☐ Other:_____________________

Neurologic

- ☐ Migraines
- ☐ Triggers:________________
- ☐ headaches
- ☐ frequency
- ☐ seen by neurologist
- ☐ prescribed
- ☐ Muscle weakness
- ☐ Other symptoms
- ☐ Visual changes
- ☐ Other______________________________

Endocrine

- ☐ Weight loss/gain
- ☐ Sweating
- ☐ Temperature intolerance
- ☐ Other______________________________

Hematology/Immunology/Oncology

- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Frequent infections
- ☐ Fatigue
- ☐ Swollen glands
- ☐ Frequent respiratory infections
- ☐ Frequent antibiotics treatment
- ☐ Other______________________________

Psychiatry

- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Bipolar disorder
- ☐ ADD/ADHD
- ☐ Other:______________________________

SOCIAL HISTORY

- ☐ Occupation:________________________
- ☐ Current smoker
- ☐ > 10/day
- ☐ < 10/day
- ☐ Past smoker
- ☐ Quit > 10 years ago
- ☐ < 10 years ago
- ☐ Had flu shot
- ☐ Had pneumovax

PEDIATRIC (IF APLICABLE)

- ☐ Full term
- ☐ Breast fed
- ☐ RSV/wheezing in infancy
- ☐ Childhood immunizations up to date
- ☐ My child is in daycare
- ☐ Shares bedroom with siblings
- ☐ Has stuffed animals in bedroom

ENVIRONMENTAL SURVEY

- ☐ My dwelling is:
- ☐ > 10 years old
- ☐ < 10 years old
- ☐ In current home:
- ☐ > 3 years
- ☐ < 3 years
- ☐ Pets:
- ☐ Cat(s) indoor
- ☐ Cat(s) outdoor
- ☐ Dog indoor
- ☐ Dog(s) outdoor
- ☐ Other:____________________
- ☐ Smoker in the household:
- ☐ Central HVAC
- ☐ Have moisture problems in your home
- ☐ Have a damp basement
- ☐ Have dust mite proof encasings
- ☐ On mattress
- ☐ On pillows
- ☐ Hard wood floor in bedroom
- ☐ Carpet in bedroom
- ☐ Symptoms get worse at work
- ☐ Symptoms improve away from home/on vacation

8100 Ashton Avenue, Suite 207B, Manassas, VA 20109 | 20528 Boland Farm Rd., Ste 214, Germantown, MD 20876
: 855-5CURE4U (528-7348) : 855-FAX CURE (329-2873) : info@allergycurecenters.com : www.allergycurecenters.com

PREMIER ALLERGY AND ASTHMA CENTERS – FINANCIAL AND GENERAL OFFICE POLICIES

Please read and review carefully

CONSENT FOR TREATMENT

The undersigned hereby agrees and consents to the administration of such medical treatment, diagnostic and/or therapeutic medical procedures for themselves and/or their children as deemed necessary by the Premier Allergy and Asthma Centers' (further PAAC) physician rendering the care. The procedures may include, but are not limited to, allergy testing, laboratory and other diagnostic procedures.

RELEASE OF MEDICAL INFORMATION/SIGNATURE ON FILE/AUTHORIZATION

I authorize AACC to release my or my dependent's medical information as necessary to process insurance claims, prior authorizations, and prescriptions. I hereby authorize PAAC to file insurance claims on my behalf for the services rendered and I authorize the insurance payments to be made to PAAC. I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic, or telephonic.

PHONECALLS: PAAC staff may need to leave medical information regarding your care on your answering machine if you are not available. Should you have any restrictions on this policy please inform our staff prior or at the time of your appointment.

FINANCIAL POLICIES

REFERRALS AND AUTHORIZATIONS:

It is your responsibility to obtain a referral from your primary care physician prior to your appointment with our specialist if it is required by your insurance. Please ask your primary care provider to file the referral authorization electronically or by fax directly with your insurance. Please forward us a copy prior to your appointment or bring it with you. Your **insurance will deny a claim without referral**. If you are seen without a referral, you will be obligated to pay for all the services rendered. **We will not be able to re-submit your claim if you obtain the referral only after you have been seen**. If you are unsure how to obtain the referral, please let the PAAC staff know, and we will be happy to help.

INSURANCE COVERAGE:

You, the undersigned, are responsible for paying at the time of service your co-pay for the services rendered to you or your minor. **If you request or consent to proposed allergy testing and your unmet deductible exceeds $350, you will be required to pay $350 prior to the testing.**

If we participate (contract) with your insurance plan, we will bill the carrier directly for charges for the services rendered. You are responsible for all co-pays, co-insurance and deductibles. We will bill both your primary and secondary insurer for contracted plans. However, if the secondary does not pay within 60 days, you will be billed for the balance.

If **we do not participate** and are out-of-network with your insurance plan, it is **your responsibility to verify that your policy includes out-of-network benefits before your visit**. **You will be responsible for all the claims balances including claim denials due to limited or no out-of-network benefits available in your policy**

It is your responsibility to be aware and inform us if your insurance coverage has limits for specific diagnostic services, such as number of allergens allowed for your testing. If you request

and receive services exceeding the limits or not covered by your plan you will be responsible for payment for those services.

CREDIT CARD AUTHORIZATION, PAYMENT AND STATEMENTS:

You will be required, at the time of service, to provide credit card information to be kept securely on file. Once your insurance claim is processed by your insurance, any remaining balance, but not to exceed $300, will be charged to your credit card. However, if a set of allergen vials is prepared, the total charge may be up to $1,500. Your signature below authorizes PACC to do so. You will be emailed and mailed a detailed billing statement monthly until the balance has been satisfied. You are responsible for paying your balance within 30 days of the statement's date. PAAC accept cash, personal checks, and certain credit/debit cards. If your **check is declined**, you will be responsible for a **$50.00 returned check fee** in addition to the original service fees.

Patients with an outstanding balance overdue by 60 or more days must make arrangement for payment prior to being seen for further visits or allergy injections. If you have any questions regarding your bill, please call our billing department for assistance at 855-528-7348 ext. 704.

We reserve the right to forward your account to a collection agency/attorney for non-payment if it is 90 or more days overdue. If the account is sent for a collection, **a surcharge of 34 % will be added to the unpaid balance**. In addition to the amount owed, you will be responsible for the collection surcharge and any additional fees/costs permitted by law associated with the collection. You understand that the collection will have a negative impact on your credit rating.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Cancelled appointments deprive other patients of the opportunity to be timely seen and waste resources of our practice. Thus, appointment cancellations and/or rescheduling are to be requested at least 24 hours prior to the appointment. If you do not show for your appointment or cancel with less than 24 hours' notice, a **"no show" fee of $50 will be charged** to your account. Abuse of scheduled appointments may result in a discharge from the practice.

REPORTS AND SCHOOL FORM FEES:

You agree to pay an administrative fee of $30 for physician's review of records and preparation of progress, summary, discharge and other reports.

School forms and similar documents are to be requested and will be completed only during a scheduled appointment.

If you require completion of a school form outside of yours or your child's regular appointment, a processing fee of $15 will be charged per form for the completion within 3 business days or $20 per form if the same day completion is requested. The fees are payable at the time of the request.

CERTIFICATION

I certify that the information I have provided to PAAC regarding applicable insurance coverage is correct and current and that I have read and understand the forgoing. As the patient/guardian/guarantor I understand and fully accept the terms and policies as well as the charges incurred as detailed above.

Patient or Responsible Party Signature: ____Date:__________

Printed Name:__________________________________Relationship to Patient: _______________________

Premier Allergy and Asthma Centers

Manassas, VA: 8100 Ashton Avenue, Suite 207 B, Manassas, VA 20109
Germantown, MD: 120528 Boland Farm Rd, Ste 214, Germantown, MD 20876
Toll Free: 1855-528-7348) **Fax:** 855-329-2873)
Web: www.allergycurecenters.com

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This is a notice that the office of Premier Allergy and Asthma Centers (further PAAC) is fully compliant with the rules and regulations of the Health Insurance Portability and Accountability Act (HIPAA).

With my consent, PAAC may use and disclose protected health information (PHI) about me, in order to carry out treatment, payment, and health care operations (Treatment, Payment, and Health Care Operations= TPO). For example: We give your health plan the information it requires before it will pay us.

I have the right to review the Notice of Privacy Practices prior to signing this consent. AACC reserves the right to revise this Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Office Manager, 8100 Ashton Ave. Suite 207B, Manassas, VA 20109.

With my consent, PAAC may call my home or other designated location, and leave a message on voice mail or in person, in reference to any item that assists the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, as well as other results.

With my consent, PAAC may mail to my home or other designated location any item that assists the practice in carrying out TPO, such as appointment reminder cards, patient result cards, and patient statements.

I have the right to request that PAAC restrict how the medical practice uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed above. You will not be penalized for filing a complaint.

By signing this form, I am consenting to PAAC's use and disclosure of my PHI to carry out TPO. I may revoke my consent, in writing, except to the extent that the practice has already made disclosures in reliance with my prior consent. If I do not sign this consent PAAC may decline to provide treatment to me.

Signature of Patient or Legal Guardian ________________________________ Date __________

Printed Name of Patient or Legal Guardian ________________________________

Please list below if you would like to add anyone, ie: spouse, partner, parent, whom we can release your medical information to:

Name: ______________________________ Name: ______________________________

Relationship: _________________________ Relationship: _________________________

Address: ____________________________ Address: ____________________________

____________________________________ ____________________________________

Phone: ______________________________ Phone: ______________________________

DOB: _______________________________ DOB: _______________________________

I understand that it is my responsibility to notify PAAC should any of the above information change.

Signature of Patient or Legal Guardian ________________________________ Date ___________

Premier Allergy and Asthma Centers

Notice of Privacy Practices

THIS NOTICE IS REQUIRED BY FEDERAL LAW AND DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the ways in which we may use and disclose your protected health information (PHI) and how you can get access to this information. Protected health information is information about you that is contained in your medical and billing records maintained by this organization. It includes demographic information and information that relates to your present, past or future physical or mental health and related healthcare services.

Uses and Disclosures of Protected Health Information: We may use and disclose your protected health information for purposes of healthcare treatment, payment and healthcare operations as described below.

For Treatment: We may use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. Examples of how we will disclose information for treatment may include sharing information about you with: referring physicians, your primary care physician, a specialist, hospitals, ambulatory care centers, pharmacies or home health agencies.

For Payment: Your protected health information will be used and disclosed as required, so that we can bill and receive payment for the treatment and services you receive from us. Examples of how we will disclose information for payment include: contacting your health plan to confirm your coverage or obtain precertification of a service, or we may provide information to any other healthcare provider who requests information necessary for them to collect payment.

For Healthcare Operations: We may use and disclose your protected health information in performing business activities that we call healthcare operations. This includes internal operations, such as for general administrative activities and to monitor the quality of care you receive at our facility. Examples include: quality of care assessments, training of medical staff, assessing certain services that we may want to offer in the future, evaluating the performance of our employees, licensing, or conducting or arranging other business activities. Other examples include: leaving messages on your answering machine; leaving messages at your place of employment or sending out recall notices. We may use or disclose your protected health information when making calls to remind you of your appointment. We will use a sign-in sheet at the receptionist's desk where you will be asked to sign your name and the name of the provider you are seeing. We will also call you by name when you are in our waiting room. **Other Uses and Disclosures We May Make Without Your Written Authorization:** Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, we may use and disclose your protected health information in which you do not have to give authorization. These situations include: those Required by Law, Public Health Risk Issues as required by Law, Communicable Diseases, Health Oversight Activities, reporting Victims of Abuse, Neglect or Domestic Violence, Legal Proceedings, Law Enforcement, (this notice continues on the back of this page) Coroners, Medical Examiners, Funeral Directors, Organ/Tissue Donation Organizations, Research; Criminal Activity; Military Activity and National Security, Inmates/Law Enforcement Custody, and Workers Compensation.

Any Other Use or Disclosure of Your Protected Health Information Requires Your Written Authorization: Will be made only with your consent, authorization or opportunity to object, unless required by law.

Your Rights Regarding Your Protected Health Information: You have the right to access your personal protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You Have the Right to Request Restrictions: You have the right to request a restriction on the way we use or disclose your protected health information for treatment, payment or healthcare operations. You may make this request in writing, at any time. If we do agree to the restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your emergency treatment.

You Have the Right to Request Confidential Communications: You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address. We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.

You Have the Right to Request that We Amend your Protected Health Information: If we deny your request, we will give you a written notice, including the reasons for the denial. You can submit a written statement disagreeing with this denial. Your letter of disagreement will be attached to your medical record.

You Have the Right to Request an Accounting of Certain Disclosures of Your Protected Health Information. You Have the Right to Obtain a Paper Copy of This Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone.

You May Issue a Complaint to our Privacy Officer (listed on the first page) or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We Reserve the Right to Change the Terms of This Notice of Privacy Practices and to make the new provisions effective for all protected health information we already have about you as well as any protected health information we create or receive in the future. If we make any changes, we will: a. Post the revised Notice in our office(s), which will contain the new effective date; and b. Make copies of the revised Notice available to you upon request.

SIGNATURE OF PATIENT/GUARDIAN/GUARANTOR　　　PRINT NAME　　　DATE

Premier Allergy
and
Asthma Centers

Adult Patient Registration Form

PATIENT INFORMATION

FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	☐ NEW PATIENT ☐ EXISTING/UPDATE
HOME ADDRESS		CITY	STATE & ZIP
E-MAIL	HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER
HOW DO YOU WANT US TO CONTACT YOU REGARDING YOUR CARE: ☐ WORK ☐ HOME ☐ CELL ☐ E-MAIL	PREFERRED PHARMACY INFORMATION:		PHARMACY PHONE NUMBER:
EMPLOYER NAME	EMPLOYER ADDRESS		
PCP/REFERRING PHYSICIAN			PCP/REFERRING PHYSICIAN PHONE NUMBER

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT	CONTACT NUMBER

INSURANCE INFORMATION Copy of insurance cards and insurance info need to be filled for benefits

POLICY HOLDER'S NAME	SOCIAL SECURITY NUMBER OF SUBSCRIBER	POLICY HOLDER'S BIRTH DATE	POLICY HOLDER'S SEX ☐ MALE ☐ FEMALE
POLICY HOLDER'S RELATIONSHIP TO PATIENT IS: ☐ SELF ☐ PATIENT ☐ SPOUSE ☐ OTHER		POLICY HOLDER'S EMPLOYER	
PRIMARY INSURANCE COMPANY	CO-PAYMENT/CO-INSURANCE AMOUNT	IDENTIFICATION/POLICY NUMBER	GROUP NUMBER
INSURANCE ADDRESS	CITY	STATE/ZIP	EFFECTIVE DATE

DOES YOUR INSURANCE REQUIRE YOU TO HAVE A REFERRAL TO SEE A SPECIALIST? ☐ YES ☐ NO

I certify that all of the information provided herein is true and correct. I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Premier Allergy and Asthma Centers. I understand that payment is due at the time of service. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

SIGNATURE OF PATIENT/GUARDIAN/GUARANTOR PRINT NAME DATE