Allergy, Asthma, & Immunology Center of SWLA

New Patient Information Packet

Welcome to AAICSWLA! We look forward to helping you and your family feel better. Please help us make your first appointment as productive and efficient as possible by filling out our new patient information packet.

These forms are due before your scheduled new patient appointment. Otherwise, we may have to reschedule your appointment for a different day. If you need help, please arrive 30 minutes before your scheduled appointment. If you have any questions about the forms, please do not hesitate to call our office at (337) 981-9495.

We look forward to meeting you and your family!

Sincerely,

AAICSWLA providers and staff

AAICSWLA Patient Information

Name (First): _____ (Last): _____ (MI): _____ **DOB**: _____ **Gender at birth**: □ M □ F

SSN: _____ **Marital Status**: □ Single □ Married □ Widowed □ Divorced

Ethnicity: □ American Indian □ Hispanic or Latino □ Asian □ Black or African American □ Caucasian □ Other: _____

Address (Street or PO Box): _____ (City, State, Zip): _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Email Address: _____ **Ok to receive text messages**: □ Yes □ No

Relatives who are patients here (If none, check here □): _____

Primary Provider (FULL NAME): _____ **Referring** (FULL NAME): _____

Spouse and Emergency Contact Information

Spouse (Name): _____ (Cell): _____

Emergency Contact (Name): _____ (Phone): _____

If patient is a minor, fill out below

The patient resides with: □ Both Parents □ Father □ Mother □ Other: _____

Mother's Name: _____ **Date of Birth**: _____ **Employer**: _____

Address (Street or PO Box): _____

(City, State, Zip): _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

SSN: _____ **Email Address**: _____

Father's Name: _____ **Date of Birth**: _____ **Employer**: _____

Address (Street or PO Box): _____

(City, State, Zip): _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

SSN: _____ **Email Address**: _____

Insurance Information (**ALL private, Medicaid, and Medicare policies MUST be reported**.)

Primary Insurance: _____

Member ID: _____Group #: _____

Secondary Insurance: _____

Member ID: _____Group #: _____

Subscriber Name: _____ Relationship to patient: _____ Subscriber SSN: _____ Subscriber DOB: _____

Pharmacy Information

Pharmacy Name and Location: _____ **Pharmacy Phone**: _____

Please sign below to attest that the information provided above, to the best of my knowledge, is accurate and complete.

_____ _____ _____

Patient/parent/guardian signature **Printed name** **Date**

Below are AAICSWLA's clinic policies. Our policies are meant to help our clinic run efficiently allowing us to provide the best care for our patients. Please ask our staff if you have any questions. Please initial each policy and sign below.

Late and no-show policy

To reschedule an appointment please contact our office at least **24 hours** before your previously scheduled appointment time. Please call to let us know if you are running late.

Appointments rescheduled or canceled within one hour of the scheduled appointment time will be documented as a "**no-show**."

Appointments rescheduled or canceled within 24 hours of the scheduled appointment time (excluding Monday appointments) will be documented as a "**same-day cancellation**."

Arriving 15 minutes early allows our clinic to run efficiently. If you are more than **20 minutes** late for your appointment, we will likely reschedule your appointment for a different day.

Patients with **three or more "no-show" or "same-day cancellation"** appointments may be dismissed from our practice.

Patients who "no-show" for their first appointment will not likely be rescheduled. New patients should complete new patient paperwork **before** their appointment time. Checkups should update any necessary insurance information **before** their appointment time.

To allow each patient the necessary time with their provider **we are not able to examine siblings or other family members** if they do not have a scheduled appointment.

Patient/parent initials: _____

Medical records, medical forms, and school forms policy

We will provide necessary food allergy action plans and asthma action plans to patients. **Completion of any additional school or sports forms carries a $15 charge per form**.

Completion of any **disability** and **FMLA** forms are at the discretion of the provider and carries a **$50 charge**. Completion requires 5 business days. Payment for form completion is collected when forms are dropped off.

Requests for **letters of medical necessity** or letters describing diagnoses and treatment plans are at the discretion of the provider and require ten business days for completion. Letters of medical necessity carry a **$75 charge per letter**. Payment for letters is collected before letters are provided to patients.

Patient/parent initials: _____

Patient name (printed) _____

Exam room and smoke odor policy

Patients and families should **refrain from eating and drinking** (water excluded) in exam rooms.

Patients and families should **refrain from using cell phones** while the nurse or provider is in the exam room, including talking on the phone and taking photos/videos.

We understand that children can get restless while waiting for the nurse or provider. If trash or food or liquids are spilled, we ask patients and families to do their best in helping to **keep our exams room clean.**

Strong tobacco or marijuana smoke odor in our waiting room and exam rooms make it difficult for our staff, providers, and patients (especially children) using the same room. We understand that quitting smoking can be extremely difficult but it is the single best thing smoking patients can do for their own health.

Patient/parent initials: _____

Patient insurance and financial policy

Our staff does their best to verify patients' insurance coverage. However, **insurance verification by our staff is not a guarantee of coverage.** It is important that patients are familiar and comfortable with the contract they have with their own insurance company.

We require patients to have insurance / pharmacy cards for every appointment or service visit. As a courtesy we will bill your insurance and collect the patient responsibility amount at the visit.

It is the patient's responsibility to inform our business staff of ANY insurance changes. Otherwise, patients may be responsible for payment in full for all services rendered.

Payment for co-pays, deductibles, co-insurance payments, or non-covered services are due at the time of service. Our clinic accepts cash, debit cards, most credit cards & personal checks.

Patients are responsible for all fees associated with non-sufficient funds (NSF). Returned checks will be charged to the patient's account as well as an additional $50 service fee.

Outstanding balances are due within 30 days. We offer payment plans if necessary.

Balances exceeding three months and without a started payment plan will go to collections. No future appointments will be scheduled until the full balance is paid.

Payment and updated insurance information at the time of service is the **responsibility of the accompanying adult – not another parent.**

Patient/parent initials: _____

Patient name (printed) _____

Patient dismissal policy

Patients can be dismissed from the practice for the following reasons:

1. Three or more "no-show" or "same-day cancellation" appointments

2. Not complying with their prescribed medical care

3. Being disrespectful, hostile, or verbally/physically abusive to **ANY** clinic staff at any time.

4. Not paying for services

A patient who is dismissed from the practice will be notified via a letter send by certified mail and regular mail to the address of record.

Following dismissal, a patient will be provided with any necessary emergency care for 30 days starting from the date the dismissal letter was mailed.

Patient/parent initials: _____

Telephone and correspondence policy

Our staff does their best to return phone calls the same day. Messages are returned typically at lunch time and at the end of the day. Repeated phone calls will not expedite a return call.

Complex/new issues may require scheduling an appointment instead of a nursing phone call.

If you have not heard about your lab results one full week after having labs drawn, please call the office. Sometimes labs do not send us timely results. We may not know when or where you had labs drawn.

Please check for remaining medication refills with your pharmacy **before** calling the office.

Do not send medical information or questions to ANY of our office email addresses. **We do NOT treat patients or answer questions via email/patient portal.** Please call us.

Patient/parent initials: _____

Acknowledgement

I have read and I understand the above policies of AAICSWLA. I agree to the above policies.

_____	_____	_____
Signature of patient/parent/guardian	Relation to patient	Date

Patient name (printed) _____

AAICSWLA Patient Medical History **Date of form completion: _____**

This form will be used as a guide by our providers and will help with the flow of your consultation. Please be accurate and complete. This form is due prior to your scheduled appointment time. Otherwise, your appointment may need to be rescheduled to a different day.

Patient Name: _____

Referring Provider (FULL NAME): _____

Primary Care Provider (FULL NAME): _____

List the three most important problems/concerns you would like addressed at your consultation.

(In order to allow our patients the necessary time with their provider, additional problems/concerns may be addressed at future visits.)

1. _____

2. _____

3. _____

Past Medical History

Medications:

_____ _____ _____

_____ _____ _____

Drug, Insect, and Food Allergies: _____

Are recommended / routine vaccines up to date? (Check one): Yes _____ No _____

Past Medical Diagnoses (Check all that apply. If no diagnoses apply, please check here: □)

□ Asthma or Bronchitis (How many oral steroid courses or injections in past 6 months? _____)

□ Recurrent Sinus Infections (How many per year? _____ Any specific season? _____)

□ Eczema / Atopic Dermatitis □ Recurrent Ear Infections (How many per year? _____)

□ Hives □ Crohn's □ Ulcerative Colitis □ IBS □ Reflux □ Eosinophilic Esophagitis

□ Hospitalized for IV Antibiotics □ Thyroid Disorder □ Celiac Disease □ Nasal Polyps

□ Pneumonia (How many in lifetime? _____) □ Cancer □ Severe infections □ Liver Disease

□ Kidney Disease □ Seizure Disorder □ Rheumatoid Arthritis □ Diabetes (Type I or II?)

□ High Blood Pressure □ High Cholesterol □ Coronary Artery Disease

□ Diagnosed Autoimmune Disease (If so, what diagnosis? _____)

□ Diagnosed Immunodeficiency (If so, what diagnosis? _____)

Patient name (printed) _____

Previous surgeries? (Check all that apply. If no diagnoses apply, please check here: □)

□ Adenoidectomy □ Appendectomy □ Thyroid Surgery □ Septoplasty □ Bronchoscopy

□ Ear Tubes □ Sinus Surgery □ Tonsillectomy □ Organ Transplant □ Esophageal Stretching

Family Medical History

(Check all that apply. If no diagnoses apply, please check here: □)

Mother: □ Allergic Rhinitis □ Asthma □ Eczema □ Food allergies □ Immunodeficiency

Father: □ Allergic Rhinitis □ Asthma □ Eczema □ Food allergies □ Immunodeficiency

Siblings: □ Allergic Rhinitis □ Asthma □ Eczema □ Food allergies □ Immunodeficiency

Children: □ Allergic Rhinitis □ Asthma □ Eczema □ Food allergies □ Immunodeficiency

Social History

What family members live at home? _____

Do you smoke or vape? (If so, how many packs per day?): _____

What do you do for work? _____

Do you work in an office, warehouse, factory, outdoors, from home? _____

Environmental History

Carpeting in the home? (If, so in which rooms?): _____

Pets / animals? (If so, what kind and are they inside or out?): _____

Are there smokers in the home, outside, or in the car? (If so, where?): _____

Bothersome Symptoms (Check all that apply. If no symptoms apply, please check here: □)

□ Nasal Congestion □ Runny Nose □ Itchy Nose □ Sneezing □ Post Nasal Drainage □ Headaches

□ Itchy/Red Eyes □ Hives / Swelling □ Cough □ Shortness of Breath □ Wheezing □ Eczema

□ Difficulty swallowing □ Frequent / Severe infections □ Immediate reactions to SPECIFIC foods

□ Contact skin reactions to metals, jewelry, cosmetics, soaps, lotions or other topical products

Triggers of allergy symptoms (dust, pollen, animals, specific seasons, foods etc.):

_____

Patient name (printed) _____

AAICSWLA Patient consent for use and disclosure of protected health information (PHI)

It is the policy of our practice that all providers and staff preserve the integrity and confidentiality of patients' protected health information (PHI). The purpose of this policy is to ensure that our providers and staff have the necessary medical and PHI to provide the highest quality of care possible while protecting the confidentiality of our patients' PHI to the highest degree possible.

Who will follow this notice?

- Any healthcare professional employed by our office
- Any clerical staff responsible for billing, scheduling, medical records, accounts receivables and payables, etc.
- Any medical student that provides care or trains in this facility
- Medical transcriptionists and electronic health records services used for clinical documentation

How can we use and disclose medical information about you?

- Treatment: We may use your medical information to assist us in providing medical treatment or services. We may need to disclose your medical information to another physician to assist us in your treatment plan. Sometimes your medical records will need to be shared with another facility to coordinate other care that you need; such as laboratory, x-rays, prescriptions, or prior authorizations. This is not an all-inclusive list.
- Payment: We may use or disclose your medical information to another facility that we are referring you to or to your health plan so that they can assist you in the filing and payment of your medical claims. We may also need to provide this information to obtain benefits or authorizations for a procedure that we have scheduled for you.
- Healthcare Operations: We may use your medical information to evaluate the quality of care and treatment that our patients are receiving. We also do this when our providers dictate your diagnosis and plan of care so that our transcriptionist can record these for our medical records. We use medical information when documenting visits or patient encounters in the electronic health record.
- We may also be required to release medical information of yours when required by Federal, State or local law.
- We may also release information to a parent or legal guardian of a minor/young adult when the guardian is financially responsible for payment of medical treatments and when the minor/young adult is requesting we use a parent's insurance plan to file the services we will provide to you.
- For members of the armed forces or veterans, we may be required to release health information as required by law.
- If you filed a workman's compensation claim we may release medical information about you to assist in these benefits.
- We may be required by law to provide your medical records to a health oversight agency for audits, investigations, inspection and licensure.
- We may release health information to authorities if we suspect there is a public risk involved such as neglect, abuse, reactions to drugs/drug products, drug recalls, or exposure to disease.
- If you are involved in a legal dispute, we may be required to release your medical records if under administrative orders such as a subpoena, warrant, summons or court order; to assist with locating a missing person, to aid in a crime, death, criminal misconduct at the facility or other emergency.
- Reasons of national security

Your rights regarding your medical records:

- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. The request must be made in writing and you may incur a charge for these records. In rare circumstances we can deny your request.
- You have a right to request a review of this request by an on-site healthcare professional. Patients have a right to request an amendment to his/her medical record if he/she believe his/her information is inaccurate or incomplete. We may deny your request for the amendment if it was not requested in writing and if the amendment is to a medical record we did not create or if the information is accurate and complete. Patients' access to their medical records must be in writing and approved by our practice. If we deny your request, we must inform you that you may request a review of our denial. In such cases, we will have an on-site healthcare professional review your appeal.
- You have a right to request an accounting of disclosures. You must submit this request in writing and must state a time frame to which you are requesting this disclosure. The request must be specific in regards to paper or electronic.
- You have a right to request a restriction on who can review your medical records or to limit the information that can be disclosed to others. Your request must be made in writing and be specific about the person or persons that are not allowed to view your medical records and specifically what information you are limiting our disclosure.
- You have a right to a paper copy of this notice. You may ask for one at any time by contacting our office.
- If you provide us with permission to use and disclose your health information it may be revoked in writing at any time.

Changes of this notice:

- We have the right to change this notice at any time.
- If you believe your privacy has been violated, you may file a complaint with our office.

Acknowledgement

I have read and understand the above policy regarding the use and disclosure of PHI. I agree to the above policy.

_____	_____	_____
Signature of patient/parent/guardian	Relation to patient	Date

AAICSWLA Release of Information and Consent to Treat a Minor

As per HIPAA guidelines, we cannot release medical / billing information without the consent of a parent or legal guardian.

Any patient under the age of 18 will not be seen without a parent, legal guardian or another authorized representative present.

Check one of the boxes below:

□ I authorize AAICSWLA to release my child's medical / billing information to the following individuals. I also authorize the following individuals to accompany my child to appointments in my absence. I consent to treatment of my child (including injections) without my presence. I understand that I may revoke this consent in writing at any time.

1. Name: _____
   Relation to Patient: _____
   Phone Number: _____
2. Name: _____
   Relation to Patient: _____
   Phone Number: _____
3. Name: _____
   Relation to Patient: _____
   Phone Number: _____

□ I do not authorize AAICSWLA to release any of my child's medical / billing information. I do not authorize anyone other than a parents/legal guardian to bring my child to appointment or consent to treatment.

Acknowledgement

I have read and I understand the above release of information and consent to treat a minor policy of AAICSWLA. I agree to the above policy.

_____ _____ _____

Signature of patient/parent/guardian Relation to patient Date

AAICSWLA Allergy skin testing policy and medications to avoid before skin testing

Patients younger than 18 years old must be accompanied by a parent or legal guardian for allergy skin testing.

Antihistamines will affect the results of allergy skin prick tests and must be stopped for seven days before testing. This is not a complete list. Below is a list of common examples. If you are not sure if the medicine you are taking is an antihistamine, ask your doctor. **Many over-the-counter cold and flu medications and sleep aids contain antihistamines. Be sure to read labels carefully for both the brand name and generic drug name** (generic antihistamine names contained in each brand name example are in parenthesis below).

- Advil Multi-Symptom Cold & Flu and Advil PM (chlorpheniramine)
- Alaway and Zaditor eye drops (ketotifen eye drops)
- Aleve PM and Aleve-D Sinus & Cold (diphenhydramine)
- Allegra and Allegra D (fexofenadine)
- Aller-Chlor and Chlor-Trimeton (chlorpheniramine)
- Antivert and Bonine (meclizine)
- Astelin, Astepro and Dymista nasal sprays (azelastine nasal spray)
- Atarax (hydroxyzine)
- Benadryl (diphenhydramine)
- Bromfed DM and Dimetapp (brompheneramine)
- Clarinex and Clarinex D (desloratadine)
- Claritin and Claritin D (loratadine)
- Coricidin HBP Cough & Cold, Cold & Flu, Nighttime Multi-Symptom Cold (chlorpheniramine)
- Dramamine (dimenhydrinate)
- Karbinal ER (carbinoxamine)
- Pataday and Patanol eye drops (olopatadine eye drops)
- Patanase nasal spray (olopatadine nasal spray
- Periactin (cyproheptadine)
- Phenergan (promethazine)
- Semprex D (acrivastine)
- Tavist (clemastine)
- (trazodone)
- TussiCaps (chlorpheniramine)
- Tussionex PennKinetic (chlorpheniramine)
- Tylenol PM (diphenhydramine)
- Vicks NyQuil Severe Cold & Flu (doxylamine) and Vicks NyQuil Children's Cold & Cough (chlorpheniramine)
- Unisom (doxylamine)
- Xyzal (levocetirizine)
- Zyrtec (cetirizine)

Patient name (printed) _____

Some reflux medications called "H2 blockers" are antihistamines and will affect allergy skin testing results. Brand name examples are listed below (generic names are in parentheses).

- Pepcid (famotidine)
- Zantac (famotidine)
- Axid (nizatidine)
- Tagamet (cimetidine)

Some psychiatric medications prescribed to treat depression and anxiety can also affect the results of allergy skin testing. Generic examples are listed below (brand names are in parentheses). Let your doctor know if you are on any antidepressants or sleep aides before your test, but **do not stop them without consulting the prescribing doctor**.

- amitriptyline (Elavil)
- amoxapine (Asendin)
- clomipramine (Anafranil)
- desipramine (Nupramin)
- doxepin (Sinequnan)
- imipramine (Tofranil)
- maprotiline (Ludiomil)
- mirtazapine (Remeron)
- nefazodone (Serzone)
- nortriptyline (Pamelor, Aventyl)
- protriptyline (Vivactil)
- trazadone (Desyrel)
- trimipramine (Surmontil)

If any of these medications are taken too soon prior to your testing appointment we may not be able to do allergy skin testing that day due to the potential of false-negative results.

Blood pressure medications called beta-blockers and certain eye drops prescribed to treat glaucoma called beta-blockers should be held for 72 hours before allergy testing. Although very rare, beta-blockers can increase the chance of severe allergic reactions to allergy skin testing. Generic examples are listed below (brand names are in parentheses). **Before stopping beta-blockers check with your prescribing provider to make sure it is ok.**

- atenolol (Tenormin)
- betaxolol (Betoptic eye drops)
- bisoprolol (Zebeta)
- carteolol (Ocupress eye drops)
- carvedilol (Coreg)
- labetalol (Trandate)
- levobunolol (Betagan)
- metipranolol (Optipranolol)

Patient name (printed) _____

- metoprolol (Toprol, Lopressor, Kapspargo Sprinkle)
- propranolol (Inderal)
- sotalol (Betapace, Sorine, Sotylize)
- timolol (Timoptic)

Inhaled steroids used for asthma, nasal steroids (Nasacort, Flonase, Nasonex, etc.) and montelukast (Singulair) will **not** affect skin testing results and **should be continued** as prescribed. **If asthma symptoms are not well controlled on the day of your appointment you may not be able to have allergy skin testing on that day.** Testing may be done at a later appointment when your symptoms are better controlled.

Do not apply lotions or creams to your back on the day of your appointment.

Acknowledgement

I have read and understand the above allergy skin testing policy of AAICSWLA. I agree to the above policy.

_____	_____	_____
Signature of patient/parent/guardian	Relation to patient	Date

Patient name (printed) _____