RAA Redding Allergy & Asthma Center

Name: _____ **DOB:** _____

Reason for your visit: _____

Medications you are currently taking: (including over the counter medicines)

Medication Name	**Dose (10 mg, 1 tsp, 2 puffs, etc)**	**Frequency (1 x day, at bedtime, as needed, etc)**

When is the last time you took an antihistamine (allergy medicine)? _____

Are you allergic to any medications? □ No □ Yes (if yes, please list)

Medication_____ Type of reaction _____

Medication_____ Type of reaction _____

Medication_____ Type of reaction _____

Past Medical History:

□ Asthma (current or in the past? _____) □ Arrhythmias □ Angina

□ COPD □ Reflux Disease □ Heart Disease □ Hives

□ Pneumonia □ Hypertension □ Heart Attack □ Eczema

□ Emphysema □ Stroke □ Epilepsy □ Chronic Bronchitis

□ Cancer: _____

□ Immune Deficiency: _____

□ Auto Immune Disease: _____

□ Psychiatric/Mental Health: _____

Trouble breathing of hives after an insect sting? □ No □ Yes (if yes, describe reaction and type of insect)_____

Have you had you flu vaccine this season? □ No □ Yes (mm/yy):_____

Recent Surgeries or Hospitalizations:

Date:_____ Reason:_____

Date:_____ Reason:_____

Family Health History:	Seasonal Allergies	Asthma	Insect Allergy (list)	Food Allergy (list)	Other:
Father					
Mother					
Sister					
Brother					

Marital Status:
□ Single
□ Married
□ Widowed
□ Partner

Smoking History:
□ Non-Smoker
□ Former Smoker: Start Year_____ Stop Year_____
□ Current Smoker: _____ pack(s) per day, for _____ years.
□ Exposed to second-hand smoke
□ Chewing Tobacco

Pets:
□ Dog(s) #____ □ Cat(s) #_____ □Bird(s) #_____ □Other _____

Home:
□ Mostly Carpet □ Mostly Hardwood

Occupation (or grade level if child/adolescent)**:** _____

Symptoms:

□ Itchy Nose	□ Runny Nose	□ Post-Nasal Drip	□ Trouble Breathing	□ Congestion	□ Itchy Throat
□ Itchy Eyes	□Watery Eyes	□ Red Eyes	□ Swollen Eyes	□ Hives	□ Itchy Rash
□ Cough	□ Sneezing	□ Wheezing	□ Difficulty Swallowing	□ Lip Swelling	□ Non-Itchy Rash

□ Other:_____

How long have you had these symptoms? _____

How often do you experience these symptoms? _____

What triggers these symptoms? (i.e., exposure to certain animals, seasons, being outdoors, etc.) _____

_____

RAA Redding Allergy & Asthma Center

Patient Name: _____

Birthdate: _____ **Gender:** □ Male □ Female

Referral Physician: _____ **Location:** _____

Primary Care Physician: _____ **Location:** _____

Your Pharmacy Name: _____ **Location:** _____

Please be aware that this office does not use an answering service after business hours. If you need emergency assistance after the office has closed, please go to your nearest emergency room.

Mailing Address: _____
Street

_____
City State Zip

Phone Numbers: _____ **(c);** _____ **(w)**

Email Address: _____

Referral Source: □ Physician □ Friends/Family □ Website/Internet □ Insurance company □ Advertisement

Emergency Contact Name: _____ **Relationship to Patient:** _____

Emergency Contact Phone Number: _____

If patient is a child, please list names of legal guardians and contact numbers:

Legal Guardian Name: _____ **Phone:** _____

Legal Guardian Name: _____ **Phone:** _____

Primary Insurance: □ Aetna □ BCBS □ Cigna □ Coventry □ Humana □ Medicare □ UHC
□ Other: _____

Primary Insurance Subscriber Name: _____

Subscriber Birthdate: _____ **Relationship:** □ Spouse □ Parent/Guardian □ Other: _____

Secondary Insurance: _____

Secondary Insurance Subscriber Name: _____ **Subscriber Birthdate:** _____

Please read the following statement and sign below:

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the physician. I also authorize Redding Allergy and Asthma Center to release any information required to process my claims.

Patient/Guardian Signature: _____ **Date:** _____

RAA REDDING ALLERGY & ASTHMA CENTER

Patient Name: _____ **Birthdate:** _____

FINANCIAL AGREEMENT

Please read the following Financial Policy and sign below:

At Redding Allergy and Asthma Center, we require patients to arrange for payment for all billed services at the time of service. This helps us reduce our administrative costs, so we can keep the cost of our services affordable. Here's how it works:

- You will be asked for a credit card or debit card when you check in
- We will store this account number in your medical record
- Your card will only be charged once the Explanation of Benefits is issued by your insurance company

We are contracted with numerous insurance companies, and will file your claim as a courtesy to you. Because every plan has different stipulations regarding payment for services received, it is your responsibility to understand your benefits. If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and your insurance company does not cover these charges, we will bill you directly. This is also our policy in the event of claim refutations, such as medical necessity or pre-existing condition denials.

Please note: you will be made aware of any outstanding balance on your account through phone calls and statements in the mail. However, after 90 days of nonpayment you will be sent to our collections agency. If you are sent to collections, there will be a $50 processing fee as well as a fee of 40% of your balance added to your account that you will be responsible for.

Please remember that you, the patient, are ultimately responsible for payment on your account. If you have any questions regarding our financial policy or your account, please call our office at 404-355-0078.

Patient/Guardian Signature: _____ **Date:** _____

NOTICE OF BALANCE PAYMENT

Please read the following Notice of Balance Payment and initial below:

You will be required to make payment, or payment arrangements, on any outstanding balance you may have accrued prior to scheduling a follow-up appointment with us.

Patient Initials: _____

NOTICE OF ALLOWABLE FEES

Please read the following Notice of Allowable Fees and initial below:

The fee ranges listed below are an estimation of the charges generally allowed by insurance companies. Please be aware that if you have not met your deductible, you may be responsible for the full amount of the charges allowed by your insurance company. *These fees are only an approximation, and they do not necessarily represent actual allowed amounts by an insurance company.*

New patient appointment: $200
Allergy skin testing: $450-900
Spirometry: $50
Exhaled nitric oxide measurement: $25

Patient Initials: _____

RAA REDDING ALLERGY & ASTHMA CENTER

Patient Name: _____ **Birthdate:** _____

Contact Phone Number: _____

MEDICAL RECORDS RELEASE

I understand that my protected health information may be requested from any healthcare provider within the past 10 years who may be involved in my health treatment, and that this information may be used to conduct, plan, and direct my treatment and follow-up among multiple healthcare providers.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

By signing below, I permit Redding Allergy and Asthma Center (RAAC) to obtain any medical records (including hospital and physician progress notes; radiology and imaging reports; laboratory and pathology reports; and any additional medical data) required for my treatment at RAAC.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Printed Name: _____

PRIVACY POLICY

Please read the following Privacy Policy and Medical Records Release statements and sign below:

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this protected health information may be used in: coordination of care with other healthcare professionals; healthcare operations such as quality assessments and physician certifications; and health insurance claims processing and reimbursement.

I am aware that I may request a copy of the Notice of Privacy Policy containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that this organization has the right to change its Notice of Privacy Policy and that I may contact this practice at any time to obtain a current copy of the Notice of Privacy Policy.

Patient/Guardian Signature: _____ **Date:** _____

RAA REDDING ALLERGY & ASTHMA CENTER

Patient Name: _____ **Birthdate:** _____

Do you have a history of asthma or chronic lung disease? □ No □ Yes

If you answered "YES", please read the NIOX Test Disclosure and sign below:

ASTHMA PATIENTS ONLY
NIOX FUNCTION TEST DISCLOSURE

At Redding Allergy and Asthma Center, we implement the **NIOX MINO® Airway Inflammatory Monitoring System** to test lung function in our patients. It is a brand new tool designed to better diagnose and monitor your asthma. Along with the tests we currently use to look at how successful pharmaceutical therapy has been, the NIOX MINO will be an additional measure that tells us your level of lung inflammation. The device employs an easy and non-invasive method of a simple 10 second exhalation that is completely painless and even a little fun!

Some of the benefits of this new technology are:

- The possibilities of lowering your dose of medication when appropriate
- The ability to adjust medication based on your individual needs
- Insight into your treatments efficacy
- Better prediction of asthma relapse and exacerbation
- Early identification and close monitoring or airway inflammation

If the test is performed, we will bill your insurance provider for the appropriate charge. If the charge is not covered, you may receive a bill for $25.00 to cover the medical costs of performing this sensitive measurement. If you do not wish to be charged for this test, please notify the staff prior to performing the test.

Patient/Guardian Signature: _____ **Date:** _____