# PATIENT REGISTRATION

**PATIENT INFORMATION**

Last Name: First Name: Middle Name:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Address: |  | City: |  | State: | Zip: |  |
| Date of Birth: |  | Social Security Number: |  |  | ❑ Male | ❑ Female |
| Home Phone: |  | Work Phone: |  | Cell | Phone: |  |

Email Address: Preferred Method to Contact You: \_\_\_\_

Status: ❑Married ❑Single ❑Divorced ❑Widowed

Race: ❑African American/Black ❑Asian ❑Caucasian/White ❑Native Hawaiian/Pacific Islander ❑Other ❑Decline Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Decline

**EMERGENCY CONTACTS**

Name: Relationship: \_\_\_\_\_\_\_\_\_\_ Phone:

Name: Relationship: Phone:

**GUARANTOR INFORMATION (or Person Responsible for Minor)**

Last Name: First Name: Middle Initial: Address: \_\_\_\_\_\_ City State: Zip: \_\_\_ Home Phone: Work Phone: Cell Phone: \_

Date of Birth: Social Security Number: \_

**INSURANCE INFORMATION**

**Is your visit with us related to a work injury or illness? YES NO**

### PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Number: Group Number:**

***If Tricare:*** ❑Active Standard ❑Active Prime ❑Retired Standard ❑Retired Prime

**POLICY HOLDER INFORMATION** ❑Check here if Policy Holder is same as Guarantor noted above

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name: | First Name: |  | Middle Initial: |  |
| Date of Birth: | Social Security Number: | Phone: |  |  |
| Relationship: | Employer/Place of Work: |  |  |  |

### SECONDARY INSURANCE COMPANY NAME:

**Policy Number: \_ Group Number:**

***If Tricare:*** ❑Active Standard ❑Active Prime ❑Retired Standard ❑Retired Prime

***If Medicare:*** ❑Still working of Spouse has Employer Group Health Plan **or**

❑ Disabled Beneficiary under 65 years of age

**POLICY HOLDER INFORMATION** ❑Check here if Policy Holder is same as Guarantor noted above

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name: | First Name: |  | Middle Initial: |  |
| Date of Birth: | Social Security Number: | Phone: |  |  |
| Relationship: | Employer/Place of Work: |  |  |  |

### PATIENT CONSENT FOR USE AND DISCLOSURE

 **OF PROTECTED HEALTH INFORMATION**

You must read and sign this consent before services are rendered.

I hereby give my consent for ***East Alabama Allergy and Asthma, PLLC* (*EAAA*)** to use and disclose protected health information (PHI) about me or my child(ren) to carry out Treatment, Payment, and healthcare Operations (TPO). “*NOTICE OF INFORMATION PRACTICES”* provides a more complete description of such uses and disclosure.

I have the right to review the “*NOTICE OF INFORMATION PRACTICES”* prior to signing this consent. A copy of “*NOTICE OF INFORMATION PRACTICES”* is provided in your new patient package, on our website, and available upon request. *EAAA* reserves the right to revise its “*NOTICE OF INFORMATION PRACTICES”* at any time.

With this consent *EAAA* may mail, fax, call, text, or email my home or other alternative locations any items that assist the Practice in carrying out TPO, such as appointment reminders and patient billing statements. I have the right to request that *EAAA* restrict how it uses or discloses my PHI to carry out TPO; however, the practice is not required to agree to these requested restrictions.

By signing this form, I am consenting *EAAA* use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, *EAAA* and its providers, may decline to provide treatment to me.

**Pharmacy Benefit Management (PBM)** Electronic–Prescribing is defined as a physician’s ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Medication History Transactions provide the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent, you are agreeing that EAAA can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for optimal treatment purposes.

|  |  |
| --- | --- |
|  |  \_  |
| Patient Name |  | or | Parent/Legal Guardian Name |
| Patient Signature |  | or | Parent/Legal Guardian Signature |
| Date |  |  | Date |

#### Permission to Release Medical Information:

I give permission for my medical information to be discussed with the below listed **individuals/Doctors**:

Name: Name:

Relationship to patient: \_ Relationship to patient: \_ \_

Phone number: \_\_ Phone number: \_ \_

# OFFICE POLICIES AND PATIENT RESPONSIBILITIES

## INSURANCE BILLED AND FEES

**Your health insurance policy is a contract between you and your health insurance company. East Alabama Allergy and Asthma, PLLC (EAAA) is not a party to that contract. Our relationship is with you, not your insurance company. As a courtesy to you, we file claims directly with your insurance company. We are affiliated with the most common insurance companies.** If your insurance company is not listed on our website, then please ask if we are able to file claims with your insurance before services are rendered.

**Deductibles, co-payments, and co-insurance are required by your health insurance company and were agreed upon by you when you accepted their insurance contract.** EAAA must contract with insurance companies agreeing to collect such deductibles, co-payments, and co-insurance in order to participate with their insurance plan. Co-payments and co-insurance must be collected at the time services are rendered. **There will be a $15 fee if we must bill you for the co-payment or co-insurance if not paid on the day of service.**

Your insurance company will send you a report (Explanation of Benefits or a Processed Claim Report) showing what we charged, what they adjusted per contracted rate, and what they paid on your behalf. This is not a bill or statement from EAAA. We receive a similar document and must process this information, review the claim, and re-file the claim if needed. As a result, statements to you from EAAA are often delayed two months or longer as we attempt to collect from your insurance company. If your insurance company has not paid to EAAA the submitted charges within 90 days, then you will be responsible for the full amount charged and you will need to pursue direct reimbursement from your insurance company.

**If your insurance requires you to be seen by your primary care physician before being referred to EAAA, such as East Alabama Medical Center’s Point of Service plan, then it is your responsibility to have this done in advance.** With such plans, your primary care provider must generate all referrals for any specialist, ER visit, x- ray study or outpatient procedure. If not, then the claim will be denied by your insurance plan and the charges will be your responsibility. Additionally, for such plans, if a specialist recommends another doctor or test, you must still get the referral from your primary care doctor or the claim will be denied, and the cost will be your responsibility. Referrals must be made before a visit; however backdated referrals may be made in emergent situations as defined by your plan and regulations posted by your primary care physician.

As our patient, we want to provide you the best care possible. Often, we need to diagnose conditions by testing, such as skin testing for allergies or lab tests for hives and treat conditions using medications and shots. We consider these diagnostic and treatment protocols as standard of care and medically necessary.

Unfortunately, there are some insurance plans that have a $200 cap per year on what they will pay for when it comes to allergy testing and treatment, or they may simply refuse to pay for a procedure or treatment that they may deem medically unnecessary. It is essentially impossible for us to know which insurance plans maintain such policies. Rather, it is you, the card holder, who is responsible for being aware of your insurance company’s coverage policies. If you have any questions regarding whether or not a particular service is covered, please check with your insurance company first. All charges are your responsibility whether or not your insurance covers them. If allergy shots are not covered by your insurance company, then you may discuss with our billing department a payment plan.

#### Please keep in mind that most insurance companies require you to meet your deductible before your coverage begins. It is essentially impossible for us to know what your deductible is, which varies from zero to thousands of dollars depending on your insurance type.

Self-pay patients must pay for services in full at the time services are rendered. Payment plans are not available for office visits. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect that amount from the other parent. If you have an unpaid balance over 60 days, you will be required to pay your balance in full before being seen in our office.

There is a $25 fee for a returned check or any payment from you that does not clear properly for any reason. This fee offsets the fee charged by our bank, as established by law. This fee is in addition to the payment that was being made by the returned check. We reserve the right to contact the Lee County District Attorney’s Worthless Check Unit for assistance collecting these payments pursuant to Section 12A-9-13.2 of the Code of Alabama.

If your records must be sent to another doctor or organization, then a signed written request is required and a copying fee of $1.00 per page for the first 25 pages and $0.50 per page thereafter will be due in full. The Medical Records Release Form, which is a HIPAA requirement, is available at our office and on our website at EAAllergy.com.

A receipt for a co-payment or co-insurance payment will be provided to you on the day of service only. If a receipt is requested at a later day, there will be a $1 charge per receipt.

Any credit or refund due to you will be applied toward future charges by EAAA. If there are no charges in the subsequent 12-month period, then you may receive the credit or refund by contacting our billing department.

The following are fees that must be paid before the paperwork will be released to the patient:

* FMLA - $25.00
* Detailed Letter / Statement / Form - $20.00
* A $5.00 fee will be charged if the paperwork / form needs to be expedited (5 business days)

### CANCELLATION AND NO-SHOW POLICIES

It is the policy of EAAA that patients need to report for their scheduled appointments. In the case that a patient is unable to make the scheduled appointment, the patient must give 24 hours advanced notice to the front office staff by calling (334) 528-0078, otherwise your chart will be marked as a No-Show for that visit. In the event a 24-hour notice is not given, then the following fees are applied: $50 for missed office visit or up to $50 for missed scheduled procedure. You will be notified of such fee, which will be due prior to the next scheduled appointment.

### TERMINATION POLICY

EAAA reserves the right to terminate our relationship with the patient if:

* Three (3) or more appointments are missed consecutively.
* Three (3) or more appointments are missed in a twelve (12) month period.
* The patient does not follow the appropriate guidelines of therapy as directed by the physician(s), including but not limited to asthma controller medications and allergy shots.
* The patient’s or the patient’s caregivers’ behavior and/or actions are offensive to EAAA Staff or EAAA Patients.

**QUEST DIAGNOSTICS LAB**

* Labs drawn inside our office are processed and billed to your insurance through a third party, Quest Diagnostics. If your insurance requires your labs to be processed by a different company, please notify our staff.
* Any questions regarding a bill from Quest Diagnostics, please contact them at (866) 697-8378
* **I have read and understand the OFFICE POLICIES AND PATIENT RESPONSIBILITIES and agree to all terms and conditions set forth herein.**

Printed Name of Patient

Patient Signature (or Legal Guardian) Date Signed



**Notice of Privacy Practices Patient Acknowledgement**

**Patient Name:** \_

I have received the *Notice of Privacy Practice* from East Alabama Allergy and Asthma, PLLC. I understand that I may request a copy of Notice by asking the receptionist. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice’s legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its *Notice of Privacy Practices* and to make changes regarding all protected health information under the control of this practice.

**Patient / Guardian Signature:** \_

**Date:** \_



**Consent for Evaluation and/or Treatment**

**IN ORDER TO RECEIVE ANY MEDICAL TREATMENT AND/OR EVALUATION FROM ALLERGY ATHMA & IMMUNOLOGY OF EAST ALABAMA THE FOLLOW CONSENT MUST BE SIGNED**

**EVALUATION AND TREATMENT:**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name), consent to diagnostic procedures and medical care as deemed necessary in the judgment of my Physician. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me. However, I understand that my Physician will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

By signing below, I hereby and understand the following Consent for Treatment

**Signed: Date:**

**Patient**

**Signed: Date:**

**Patient Parent/Legal Guardian**

# MEDICAL HISTORY AND ALLERGY SURVEY

1925 E. Glenn Ave., Auburn, AL 36830

125 Alison Drive, Ste. 2 Alex City, AL 35010

Phone (334) 528-0078

FAX (334) 528-0079

[www.EAAllergy.com](http://www.EAAllergy.com/)

**Name (Dr. Mr. Mrs. Ms.) Age**: **DOB: Today’s Date:**  **If patient is a minor, Parent/Guardian name and relationship If patient has any Special Needs (Deaf, Mute, Mentally Challenged) please list:**

**Doctor who referred you to see us? If not, Doctor referred, how did you hear**

**about us? Who is your Primary Care Physician?**

**Name of Pharmacy: Address of Pharmacy: What are your expectations from this visit?**



**Circle the allergy problems that you have or would like evaluated:**

**Nasal Allergies Asthma Insect Allergy Cough Medication/Drug Allergy**

**Rash/Eczema Sinus Problems Hives/Urticaria Swelling/Angioedema Food Allergy**



#### Review of Systems:

Please check if you have recently experienced any of the following:  **All normal**

**General:**

 fever

 chills

 feeling poorly (malaise)

 feeling tired (fatigue)

 weight loss (unintentional)

 loss of appetite

**Eyes:**

 itchy/burning/redness

 watery

 dry eyes

 slow change in vision

**Ears, Nose, Throat:**

 ears itch

 earache

 trouble hearing

 ears pop

 runny nose

 nosebleeds

 sores inside nose

 sores inside mouth

 dry mouth

 hoarseness of voice

**Cardiovascular:**

 chest pain

 chest pain with exercise

 calf pain with exercise

 palpitations

 ankle swelling

 shortness of breath when lying flat

**Respiratory:**

 shortness of breath

 wheezing

 cough

 cough up blood

 shortness of breath with exercise

**Gastrointestinal:**

 heartburn

 nausea

 vomiting

 diarrhea

 abdominal pain

 trouble swallowing

**Genitourinary:**

 trouble starting urine

 burning with urination

 loss of urine with cough/sneeze

 frequent urination during the night

 blood in urine

**Integument:**

 skin itches

 dry skin

 rash

 recurrent skin infections

 episodes of flushing

 spot won’t heal

**Neurologic:**

 dizziness

 fainting

 weakness/clumsiness

 tingling, burning, or numbness of hands and feet

**Musculoskeletal:**

 morning joint stiffness or aching

 painful, swollen joints

 muscle tenderness or pain

 muscle weakness

**Endocrine:**

 cold intolerance

 heat intolerance

 increased thirst

 frequent urination

**Psychiatric:**

 fearful, anxious

 excessive worry

 crying spells

 trouble sleeping

 behavior problems

**Hematologic/Lymphatic:**

 anemia

 bleed or bruise easily

 swollen lymph nodes

**NURSE NOTES:**

**Personal and Family Medical History**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Patient** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| **Nose Allergy** |  |  |  |  |  |  |  |
| **Eye Allergy** |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |
| **Eczema****(Atopic Dermatitis)** |  |  |  |  |  |  |  |
| **Food Allergy** |  |  |  |  |  |  |  |
| **Drug Allergy** |  |  |  |  |  |  |  |
| **Insect Allergy** |  |  |  |  |  |  |  |
| **Hives** |  |  |  |  |  |  |  |
| **Angioedema** |  |  |  |  |  |  |  |
| **Autoimmune Disorder** |  |  |  |  |  |  |  |
| **Immune Disorder** |  |  |  |  |  |  |  |
| **Recurrent Pneumonia** |  |  |  |  |  |  |  |
| **Migraine** |  |  |  |  |  |  |  |
| **Meningitis** |  |  |  |  |  |  |  |
| **Thyroid** |  |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |  |
| **Glaucoma** |  |  |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |  |  |
| **Cancer** |  |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |  |
| **Heart Disease** |  |  |  |  |  |  |  |
| **Bleeding Disorder** |  |  |  |  |  |  |  |
| **Heartburn or Reflux** |  |  |  |  |  |  |  |
| **Hepatitis (Liver)** |  |  |  |  |  |  |  |
| **Kidney Disease** |  |  |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |  |  |
| **Epilepsy/Seizures** |  |  |  |  |  |  |  |
|  **HIV (OPTIONAL)** |  | …….. | ………. |  .  | .  |  .  |  . |
| **List Any Other Medical Problems:** |
|  |

**Hospitalization:**  None

**Surgical History:**  None

#### List of Current Medications:  None

**Drug Allergies:**  None

**Personal History for Adults:**

Are you currently Pregnant or Breast feeding? **Yes No**

Do you smoke? **Yes No**

Did you used to smoke? **Yes No**

How many years? \_

How many packs per day? \_\_ When did you quit?

Do you drink alcohol? **Yes No**

How many drinks per week? \_ Do you use recreational drugs? **Yes No**

**Personal History for Children:**

**Birth history:**

Born full term? **Yes No**

Complications? **Yes No**

Birth weight? Developmental delays? Immunizations up-to-date? **Yes No**

Breast fed? **Yes No**

Type of formula used? Attend **school** or **daycare**? Exposed to cigarette smoke? **Yes No**

#### Environment:

Occupation: \_

Do you live in a **house**, **apartment**, **condo**, or **mobile home**? How old is the home?

Carpet? **Yes No** Which rooms? Indoor pets: Outdoor pets/animals: Air conditioning: **central** or **window units**?

Pillow: **feather**, **foam**, or **polyester fiber**? Bed: **regular**, **feather**, or **water bed**?

Do you use a **humidifier**, **air purifier**, **ceiling fans**, or **fireplace?**

**Cockroaches** or **rodents**?

**Mold** or **mildew** exposure?