Thank you for choosing Northeast Allergy Asthma & Immunology

Patient: _____ Date of birth: _____ Date of Appointment: _____

The appointment is scheduled with: _____ Location: _____

Welcome! Here is your New Patient Packet

Enclosed you will find information and instructions for your first visit with us. Along with:

- HIPAA Consent to treat and bill your insurance form
- HIPAA Omnibus Notice of Privacy Practices
- New Patient Form
- Patient Demographics Form

Please complete the forms and bring them with you to your appointment.

Important information regarding appointment

- **Missed Appointment Fees:** To ensure appointment availability for our patients, we charge a "no show" fee for missed appointments that are not canceled at least 24 hours in advance. The charge is $25 for follow up appointments and $50 for new patient appointments. Please make every effort to keep your appointment for the time and date it's made. Thank you.
  We now charge a $75 fee for "Challenge" no shows.
- **Insurance Plan Deductibles:** Does your insurance plan have a deductible? Please be advised our office charges $150 towards your annual deductible. This is only done annually and is credited towards your deductible. Any remaining balance will be billed after your insurance is processed. We appreciate your co-payment at the time of your visit. Thank you.

Information for Your Upcoming Testing Visit

IMPORTANT Information for your upcoming visit:

Antihistamines and decongestants can interfere with skin testing by blocking the allergic response. In order for us to give you accurate test results please stop all prescription and over the counter antihistamines and decongestants **PRIOR** to your appointment. These medications include:

- cough and cold remedies
- motion sickness medications
- sleep aids

Some antihistamines are longer acting. These must be stopped for **7 days before** allergy testing :

- Cetirizine/Zyrtec
- Cortisone cream to the arms or back
- Desloratadine/Clarinex
- Doxepin/Sinequan
- Fexofenadine/Allegra
- Loratadine/Claritin/Alavert/or generic
- Levocetirizine/Xyzal
- Hydroxyzine/Atarax/Vistaril
- Cyproheptadine/Periactin
- Azelastine HCL/Astelin/Astepro

Stop **three days before** the test:

- Olopatadine/Patanase
- Sudafed
- Tussinex
- Actifed
- Advil Allergy/Sinus
- Chlorpheniramine/Chlortrimetron
- Contac
- DayQuil
- Deconamine
- Dimetapp
- Diphenhydramine/Benadryl
- Drixoral
- Duravent DA
- Dura-tap
- Zantac/Rantitidine

All other cough/cold medicines should be stopped **two days** before the test.

The following medications can interfere with allergy skin testing, but should not be stopped unless under the instruction of the prescribing physician:

- Amitriptyline/Elavil
- Desipramine/Norpramin
- Nortriptyline/Pamelor
- Imipramine/Tofranil
- Trazodone/Desyril
- H2 Blockers such as Pepcid AC, Pepcid Oral, Zantac etc...

If you are on any beta-blockers (Tenormin/Atenolol, Lopressor/Toprol-XL/Metoprolol, Corgard/Nadolol, Trandate/Labetalol, Inderal/Propranolol, or Normodyne), please contact our office prior to your appointment for further instruction.

DO NOT STOP ANY ASTHMA MEDICATIONS or nasal steroids. Do not stop Singulair. Do not stop any inhalers. Do not stop any blood pressure medications or eye drops, unless this has been arranged with your primary care physician in advance. Most drugs do not interfere with testing, but make certain that your physician and nurse know about every drug you are taking (bring a list or the drugs if necessary). Please do not wear perfumes or aftershaves on the day of your appointment as it may be irritating to another patient with respiratory symptoms. Please do not bring nut containing foods into the office. Please allow a minimum of 2 hours for this appointment.

**Most standard allergy skin tests for environmental allergens and foods may be performed at the initial visit, provided you have stopped taking certain medications that interfere with testing (see page 2). Please understand that some specialized tests require preparation beforehand and will have to be performed at a follow up visit.

Patient Demographics

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Sex _____ Email _____

Mailing address _____

City _____ State _____ Zip Code _____

Primary Contact # _____ Secondary Contact # _____

Preferred form of contact for appointment reminders: ☐ Home ☐ Cell ☐ Email ☐ Text

Pharmacy

Name & Address _____

City _____ State _____ Zip Code _____ Phone _____

Please check one in each column

Race
- ☐ Caucasian/White
- ☐ Hispanic
- ☐ African American/Black
- ☐ Asian
- ☐ er _____

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ er _____

Language
- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Indian
- ☐ Other _____

Primary Emergency Contact Name: _____

Phone Number _____ Relationship _____ Legal Guardian? ☐ Yes/No ☐

Secondary Emergency Contact Name: _____

Phone Number _____ Relationship _____ Legal Guardian? ☐ Yes/No ☐

Acknowledgement of Patient Privacy Rights (HIPAA)

I, _____(print name) hereby acknowledge that I was offered a copy of NEAAI Joint Notice of Information Practices. I understand that this notice describes how the practice uses and discloses my medical and billing information as well as description of my rights and how I may obtain additional information.

☐ I would like a copy ☐ I would not like a copy

_____ _____ _____

Signature of Patient/Parent/ Legal Representative | Date | Relationship to patient

Patient Name _____ DOB _____

(OPTIONAL) In order to remain compliant with medical information laws, written authorization must be provided if you wish us to share protected medical information with anyone other than a minor's legal guardian. Consent must also be provided by a patient once they reach the age of 18 years old if they wish to authorize any other adult to contact our office on their behalf or request medical information.

_____ _____ _____

Name | Relationship to patient | Phone number

_____ _____ _____

Name | Relationship to patient | Phone number

If you wish to limit access to your protected health information, please identify the medical information that you do not wish to be shared: _____

By signing below you hereby give permission to Northeast Allergy, Asthma, & Immunology (NEAAI) to relay such information to the individuals listed here. Please note: This authorization does not grant permission to the individual(s) listed above to act on your behalf as your Health Care Proxy.

_____ _____

Signature | Date

(This consent form is considered **valid for three years** from the date of signature unless revoked in writing **or a new consent form is submitted.** This consent form now supersedes all previous consent forms and any individuals designated on those forms. Please inform the individual(s) listed above that they may be required to provide identification when requesting information.

Financial Policy: NEAAI requests prompt payment of all outstanding financial balances. If you have any questions regarding your bill or your insurance company's Explanation of Benefits (EOB) statements, please call our office. We recognize that some of our patients may experience financial difficulties at times, so please let us know if we can assist you with creating a comfortable payment plan that will accommodate your family's budget. Unfortunately, failure to comply with this policy may result in discharge from the practice.

"No-Show" Policy: NEAAI defines a "no-show" appointment as any scheduled appointment in which the patient (1) does not arrive for appointment and does not call the office (2) Cancels an appointment less than 24 hour before the scheduled appointment time with an inappropriate reason (3) Arrives late to their appointment without calling ahead and is consequently unable to be seen. After continued infringements of the NEAAI "no-show" policy, we reserve our right to discharge the patient from our practice, as we may no longer feel comfortable managing the care of this patient who chooses to continually jeopardize his or her own healthcare, or that of their children.

I hereby authorize medical treatment for myself and the release of any medical information necessary to process all insurance claims to my insurance carrier(s) and the payment of such directly to Northeast Allergy, Asthma, & Immunology (NEAAI). I also understand and acknowledge that any charges for medical care provided that are either not covered by my medical insurance or not reimbursed directly to NEAAI, including all plan deductibles, are my personal financial responsibility, I hereby acknowledge that all fees, costs, etc. (including legal fees and court costs) associated with the collection of any unpaid fees are also my personal responsibility, I hereby acknowledge that the details (what "covered charges" are; what the annual and per visit deductible costs are, etc.) of the medical insurance coverage that I have is solely my responsibility to understand prior to any medical care provided to me by NEAAI; as well as all tests, lab work and other related medical activity recommended to me by NEAAI. I also hereby authorize the staff of NEAAI to view my prescription history through external resources.

Signature of Patient/Parent/ Legal Representative | Date | Relationship to patient

New patient information:

Patient Name: _____ Date of Birth: _____ Appointment Date: _____

Address: _____

Parent/Guardian: _____ Parent/Guardian: _____

Parent address (if different): _____

Home Phone: _____ Cell Phone (Patient or Parent): _____

Pharmacy (name and address): _____

Occupation: _____ Referring doctor name: _____

Doctor's address: _____

Reason for visit today (Why are you here?): _____

_____

Hospitalizations: _____

Surgeries: _____

Allergic reactions to Medications (ie. Penicillin allergy): _____

Daily Medications: _____

_____

Medications taken as needed: _____

Home Environment

Do you live in a ☐ House or ☐ Apartment?

Are there any pets? ☐ Yes ☐ No. If so what? _____

What kind of heating do you have?

☐ Forced hot air (comes in through vents)
☐ Base board heating
☐ Wood burning stove
☐ Radiators

Any problems with:

☐ Mice
☐ Roaches
☐ Mold

Air conditioning?

☐ Central window unit
☐ None

In the patient's bedroom are there:

Stuffed toys on the bed ☐ Yes ☐ No

Feather Bedding ☐ Yes ☐ No

Carpeting ☐ Yes ☐ No

Does anyone smoke at home? _____

For adult patients: Have you ever smoked: ☐ Yes ☐ No

If so how much? _____ packs per day, _____ years _____ Quit date: _____

Drink Alcohol? ☐ Yes ☐ No

Other information you want us to know:

Review of Systems:

Check any of the following problems that the patient has (not family members):

PLEASE CHECK NONE if applicable:

General:

- ☐ Fevers
- ☐ Fatigue
- ☐ Weight loss
- ☐ Feeling cold or hot when others are comfortable
- ☐ None

Musculoskeletal:

- ☐ Arthritis
- ☐ Swollen joints
- ☐ Lyme disease
- ☐ None

Neurologic:

- ☐ ADHD
- ☐ Developmental delay
- ☐ Seizures
- ☐ Migraine
- ☐ None

Skin:

- ☐ Eczema
- ☐ Hives
- ☐ Swelling
- ☐ Psoriasis
- ☐ Other rashes
- ☐ None

Eyes:

- ☐ Itchy
- ☐ Red eyes
- ☐ Cataracts
- ☐ Eye infections
- ☐ None

Heart:

- ☐ Abnormal rhythm
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Coronary artery disease
- ☐ None

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Other
- ☐ None

Nose:

- ☐ Hay fever
- ☐ Sinus infections
- ☐ Chronic sinus pressure
- ☐ Stuffy nose
- ☐ Inability to smell
- ☐ Itchy nose
- ☐ Runny nose
- ☐ None

Ears:

- ☐ Recurrent ear infections
- ☐ Hearing loss
- ☐ None

Chest:

- ☐ Chronic cough
- ☐ Wheeze
- ☐ Recurrent pneumonia
- ☐ COPD
- ☐ Asthma
- ☐ Chest pain
- ☐ None

Lymphatics:

- ☐ Swollen lymph nodes
- ☐ Abnormal lymph nodes
- ☐ None

Gastrointestinal:

- ☐ Stomach pain
- ☐ Acid reflux
- ☐ Heartburn
- ☐ GERD
- ☐ Ulcers
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ None

Throat:

- ☐ Recurrent strep throat
- ☐ Sore throat
- ☐ Post nasal drip
- ☐ Tonsillitis
- ☐ None

Endocrine

- ☐ Diabetes
- ☐ Growth problems
- ☐ Thyroid problem
- ☐ None

Genitourinary:

- ☐ Recurrent urinary tract infections
- ☐ Renal disease
- ☐ Prostate problems
- ☐ None

Hematologic:

- ☐ Anemia
- ☐ Sickle cell
- ☐ None

Family History

Please check any of the following if the patient's parents, siblings, grandparents, or cousins have them:

- ☐ Asthma
- ☐ Seasonal allergies
- ☐ Lupus
- ☐ Heart disease
- ☐ Eczema
- ☐ Food allergies
- ☐ Hives
- ☐ Immune defect
- ☐ Thyroid disease
- ☐ Indoor allergies
- ☐ COPD
- ☐ Other: _____