Patient Medical History

Name: _____**Date of Birth:** _____

What is your goal(s) for this visit today? _____

_____

When is the last time you took an antihistamine (Benadryl, Zyrtec, Claritin, Allegra, Zyzal, etc.)**?**

_____

For patients 65 years of age, or older: Have you received the pneumococcal vaccination?
_____ Yes _____ No

Vaccines help prevent pneumococcal disease, which is any type of illness caused by Streptococcus pneumoniae bacteria. There are two kinds of pneumococcal vaccines recommended in the United States: Pneumococcal conjugate vaccines (PCVs, specifically PCV15 and PCV20) & Pneumococcal polysaccharide vaccine (PPSV23).

If "No," would you like to receive the pneumococcal vaccination, today?

_____ Yes _____ No

Have you been experiencing any of these symptoms lately? (CHECK BOX)

Itchy Eyes___	Runny Nose___	Trouble Breathing___	Eye Swelling___
Watery Eyes___	Congested Nose___	Wheezing___	Hives___
Red Eyes___	Sneezing___	Difficulty Swallowing___	Itchy Rash___
Swollen Eyes___	Itchy Throat___	Lip Swelling___	Non-Itchy Rash___
Itchy Nose___	Cough___	Face Swelling___	Other: _____

For how long have you had these symptoms?

_____

Current Medications: Please list all prescription and over the counter medications and supplements/vitamins.

Name of Drug	**Dosage** (2 mg, 2 puffs, 1 tsp, etc.)	**Frequency** (1 x day, as needed)

<u>If you are here for Drug Allergies or Adverse Reactions</u>:

List all medications **<u>and symptoms</u>:** _____

_____

<u>If you are here for hives and/or swelling:</u>

How **<u>long</u>** have you had the symptoms?

_____

How **<u>often</u>** do you have the symptoms?

_____

What triggers your symptoms: (CIRCLE)?

Heat Cold Pressure Exercise Medications Not sure

Other: _____

<u>If you are here for insect sting allergy:</u>

When did your reaction occur? _____ What type of insect: _____

Symptoms that occurred after sting: (CIRCLE)

Swelling at sting site Lip/tongue/throat swelling Hives Trouble breathing Vomiting

Other: _____

Treatment received for reaction: _____

Patient Name: First_____ **Middle**_____ **Last**_____

Birthdate: _____ **Sex:** □ Male □ Female **Race:** _____

Social Security Number: _____ **(Optional)**

Referring Physician: _____ **Location:** _____

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

Your Pharmacy Name: _____**Location:** _____**(address or intersection)**

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.

Complete Mailing Address: _____
Street Apt/Unit/Lot (if applicable)

_____
City State Zip

Phone Numbers: (Cell) _____ **(Home)** _____

E-mail Address: _____ **(If under 18, please provide a parent's e-mail address.)**

Referral Source: (CIRCLE) Physician Friends/Family Internet Insurance company Hospital DearDoc Current Patient

Emergency Contact Name: _____**Phone Number:** _____

If patient is under 18 years old, please list names of legal guardians and contact numbers:

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

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

Primary Insurance: _____ **ID #**_____

Primary Insurance Phone Number: _____

Primary Insurance Subscriber Name: _____ **DOB:** _____ **Relationship:** _____

Secondary Insurance: _____ **ID#**_____

Secondary Insurance Phone Number: _____

Secondary Insurance Subscriber Name: _____ **DOB:** _____ **Relationship:** _____

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 Specialists to release any information required to process my claims.

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

REDDING ALLERGY & ASTHMA SPECIALISTS

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 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 Specialists 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: _____

It is often helpful if our office sends your office notes, lab results, imaging reports, testing results, etc., to your primary care physician and referral physicians. By signing below, I authorize any and all medical records to be released to my primary care physician and referral physicians. I also authorize Dr. Redding and his nurses to discuss any of my medical conditions with my primary care and referral physicians.

Patient/Guardian Signature: _____ Date: _____

For patients 18 years of age, and older: I hereby authorize you to discuss medical and/or billing information with the following people (please include name and relationship to you): _____

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. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

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 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:_____

REDDING ALLERGY & ASTHMA SPECIALISTS

Patient Name: _____ Birthdate: _____

FINANCIAL AGREEMENT

Please read the following Financial Policy and sign below:

At Redding Allergy and Asthma Specialists, we require 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 e-mailed statements and mailed statements. However, after 90 days of nonpayment you will be sent to our collections agency. If you are sent to collections, there will be a $25 processing fee that will be added to your original balance.

Please be advised that when we verify your benefits, we are dependent upon the information given to us at that time. However, you are ultimately financially responsible.

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: $150-$450
Allergy skin testing: $500-$1,100
Asthma testing/spirometry: $65-$150
Asthma testing/exhaled nitric oxide measurement: $30

Patient Initials: _____

REDDING ALLERGY & ASTHMA SPECIALISTS

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 Specialists, 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, you understand that the service listed is not considered an eligible reimbursable benefit from your insurance and your financial responsibility is **$30.00**. Since you have chosen to obtain the service(s) listed above, you agree to be financially responsible for all related charges, and agree to not request reimbursement from your medical insurance company.

If you do not wish to be charged for this test, please notify the staff prior to performing the test.

Patient/Guardian Signature: _____Date:_____