



COLUMBIA

ALLERGY and ASTHMA SPECIALISTS

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1601 E. Broadway, Suite 160
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New Patient Form

Today's Date: _____

Name: _____ Birth Date _____ Social Security # _____
Address _____ City _____ ST _____ Zip _____
Marital Status: single married divorced widowed/widower domestic partner
Home # _____ Cell # _____ Email _____
Employer _____ Work Phone _____

Emergency

Contact: _____ Relationship _____
Home # _____ Work # _____ Cell/Other # _____

Responsible Party or Bill to Information:

Full Name _____ Relationship _____ Birth Date _____
Address if different from above _____
Home # _____ Work # _____ Cell _____ SS# _____

Primary Insurance:

Insurance Carrier _____ Policy # _____ Group# _____
Subscriber's Name _____ DOB _____ SS# _____
CoPay amount \$ _____

Secondary Insurance:

Insurance Carrier _____ Policy # _____ Group# _____
Subscriber's Name _____ DOB _____ SS# _____

Primary Physician: _____ Phone _____

How did you learn about us: Friend Relative Yellow Pages Physician Insurance
 Website Facebook Radio _____

Chief Complaint:

How long has this been a problem? _____
Past Medical and surgical history: _____

Current Medications: Prescription, Inhalers, over the counter, supplements etc.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient Name and DOB: _____

What is your preferred pharmacy? _____

Do you have any medication allergies? Y N

What medications and reaction? _____

Do you have any food allergies? Y N What foods? _____

Do you have any insect allergies? Y N

Have you ever had allergy testing before? Yes No

If yes, name of previous allergist and when? _____

Have you ever been on allergy shots before? Y N If yes, how long? _____

Family history: Please mark any family members that have experienced any of the following conditions: asthma, allergies, sinusitis, bronchitis, COPD, emphysema, migraines, eczema or hives

mother father brother sister aunt uncle

grandmother grandfather N/A adopted

Living/Work Environment:

Do you have any pets? Y N If yes, what kind and how many? Inside the home?

Home or apartment? _____ Type of heat? _____ Air condition? _____

Any filters inside the home? _____ Floor types? carpet hard wood vinyl tile

Do you have curtains? _____ Blinds? _____ Cleaning frequency _____

Are there any smokers in the home? _____ If yes, how many? _____

Plants? How many? _____

Do you have hypoallergenic mattress covers and pillows on your bedding? Y N

Work/School Environment? _____

What is your worst time of year? Spring Summer Fall Winter

Triggering factors:

heat cold night day foods cleaning agents laughter

candles cats dogs trees grass lawn mowing dust

metals weeds smoke illness weather changes wind

other please list _____

Do you smoke? Y N If yes, how many years? _____ How much per day? _____

Review of systems:

<u>Ears</u>	<u>Eyes</u>	<u>Nose</u>	<u>Throat</u>	<u>Sinus</u>
Popping	Tearing	Runny	Pain	Pain
Fullness	Itch	Itch	Itch	Drainage
Recurrent Infection	Redness	Sneeze	Redness	Pressure
Tubes	Change in vision	Bleeding	Hoarseness	Infection
Hearing Loss	Other	Blockage	Tonsillectomy	Other
Other		Polyps	Adenoidectomy	
		Loss of smell	Other	
		Other		

<u>Skin</u>	<u>Respiratory</u>	<u>Gastrointestinal</u>
Itch	Cough	Nausea
Burn	Wheeze	Vomiting
Rashes	Shortness of breath	Reflux/heartburn
Hives	Exercise	Food Intolerance
Eczema	Night cough	Other
Dryness	Day cough	
Other	Other	

Patient Name and DOB: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent and authorization for COLUMBIA ALLERGY and ASTHMA SPECIALISTS, to provide examination, treatments, and services by a licensed provider to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments, and services.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance company to pay benefits directly to COLUMBIA ALLERGY and ASTHMA SPECIALISTS, or its designee, for services rendered, and agree that I am financially responsible for non-covered services. I also authorize COLUMBIA ALLERGY and ASTHMA SPECIALISTS, to release any and all requested information pertaining to treatment necessary to process claim(s) benefits. (Physician, Insurance company, Attorney, etc)

***PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
AND PATIENT RIGHTS AND RESPONSIBILITIES***

I, _____, have been provided access to, and have been offered a copy of, the notice of privacy practices followed by COLUMBIA ALLERGY and ASTHMA SPECIALISTS, and I was also provided with a copy of the summary of the Privacy Practices and Patient Rights and Responsibilities followed by COLUMBIA ALLERGY and ASTHMA SPECIALISTS. I have read and understand Assignment and Release and Financial Policy Statement as set forth above. I have had an opportunity to read all these documents and ask questions.

I consent and agree to all the terms and conditions as set forth in these documents.

Signature of Patient: _____

If patient is a minor, Signed for Patient by: _____ Relationship: _____

Today's Date: _____ **Witness:** _____

FINANCIAL POLICY AND AGREEMENT

We, the staff at Columbia Allergy and Asthma Specialists, thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact our office manager at (573) 777-4700. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa and in-state checks). A \$35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest

Interest of 1.5% will incur if a balance remains unpaid after 60 days.

Patient name: _____ DOB: _____

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier.

It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out of network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports or extra-curricular activities there will be an administrative fee, not to exceed \$35.00, for the additional information.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically \$50.00 but not to exceed half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files and or summaries.

Payments

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: _____

Date: _____



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Alpha-1 Antitrypsin Testing

Alpha-1 Antitrypsin Deficiency is a hereditary condition that is passed on from parents to their children genetically. This condition may result in serious lung disease in adults and/or liver disease in infants, children, and adults.

Alpha-1 occurs when there is a severe lack of a protein in the blood called alpha-1 antitrypsin (AAT) that is mainly produced by the liver. The main function of AAT is to protect the lungs from inflammation caused by infection and inhaled irritants such as tobacco smoke. The low level of AAT in the blood occurs because the AAT is abnormal and cannot be released from the liver at the normal rate. This leads to a buildup of abnormal AAT in the liver that can cause liver disease.

Testing for Alpha-1 is fairly simple, quick, highly accurate, and free to our patients. We encourage all of our patients to participate in this preventative testing. Upon consent, testing will be performed in our clinic by collecting a small blood sample via finger stick. The testing is mailed to a lab and takes up to 2 weeks for results to be received.

I consent to AAT testing being performed:

Patient/Guardian Signature: _____ Date: _____

I decline to have AAT testing performed at this time:

Patient/Guardian Signature: _____ Date: _____

For office use only:

Testing performed (date and initials): _____

Specimen mailed (date and initials): _____



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HIPAA Consent and Acknowledgement

I give CAAS my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review CAAS's Notice of Privacy Practices (for more complete descriptions of uses and disclosures) before signing this consent.

I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used.

However, I also understand that CAAS is not required to agree to the request. If CAAS agrees to my requested restriction, they must follow the restriction.

I also understand that I may revoke this consent at anytime, by making a request in writing except for information already used or disclosed.

Printed Name: _____

Signature: _____ Date: _____
(Patient, Parent or Legal Guardian)

If signed by patient representative, state relationship to patient: _____

I authorize CAAS to discuss my protected health information with the following:

_____ Relationship: _____

_____ Relationship: _____

Signature: _____ Date: _____

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and privileged information for the use of the designated recipients named above. The designated recipients are prohibited from redistributing this information to any other party without authorization and are required to destroy the information after its stated need had been fulfilled. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited by federal or state law. If you have received this communication in error, please notify me immediately by telephone at 573.777.4700, and destroy all copies of this communication and any attachments.