COLUMBIA
ALLERGY and ASTHMA SPECIALISTS

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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 __ 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:

Ears	Eyes	Nose	Throat	Sinus
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		

Skin	Respiratory	Gastrointestinal
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 RESPONSIBILITES

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

I authorize direct payment from my insurance/Medicare benefits be made directly to the provider of Columbia Allergy and Asthma Specialists who rendered medical services to me. I authorize any holder of medical information about me to release to the insurance carrier or the Centers for Medicare and Medicaid Services any information needed to determine these benefits. I also understand I am financially responsible for the charges regardless of my insurance coverage.

I recognize that any third-party medical coverage I may have (through either an insurance policy or governmental program) is a contract between myself and the third-party payor. However, I understand that the staff of Columbia Allergy and Asthma Specialist will make reasonable effort to collect all appropriate benefits from my third-party payor(s).

In recognition of the above, I agree and promise to pay all charges identified as patient responsibility incurred for services provided to the patient. I agree to pay all cost incurred in the collection of any unpaid balance, including reasonable attorney fees if necessary. I agree that any court actions relating to this account may be brought in Boone County, Missouri.

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.

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

Signature of Insured or Authorized Representative: _____
Date: _____

Patient Name and DOB:_____

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

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.

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.

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.

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 policies for Interest, Payments, Insurance, Miscellaneous Forms, Additional Information and Authorizations, Missed Appointments, Medical Record Fees and Timeliness of appointments. By signing below, I agree to abide by the above policies.

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:_____