Allergy & Asthma Care

John Seyerle, MD and Ashish Mathur, MD
Board Certified, Allergy and Immunology

Specializing in Adult and Pediatric Allergies and Asthma

You have an appointment scheduled with Allergy & Asthma Care, Inc. at the following address:

Kenwood Office
4760 E. Galbraith Road #107
Cincinnati, Ohio 45236
(phone) 513.791.1143
(fax) 513.686.4572

You can visit our website at [www.allergy-asthmacare.com.](http://www.allergy-asthmacare.com) Please call 513.791.1143 with any questions or concerns.

ALLERGY & ASTHMA CARE, INC.

Please present this completed form to the receptionist with your insurance card(s).

PATIENT INFORMATION

PATIENT NAME (First) _________________ (MI) ____ (Last) _______________________
Social Security# __ __ __ - __ __ - __ __ __ __ DOB __ __ /__ __ /__ __ __ __ Sex: __M __F
Street Address ____
City ____ State ___________ Zip __ __ __ __ __
Home Phone (__ __ __) __ __ __ - __ __ __ __ Cell Phone (__ __ __) __ __ __ - __ __ __ __
Email _________________________ @ _________________ Marital Status _______________
Referring Doctor ____

INSURANCE INFORMATION **(All requested information is required to file your claims.)**

PRIMARY INS ___________________________________ Eff Date __ __ /__ __ /__ __ __ __
Claims Address ____
ID# _______________________________________ Group# _____________________________
Patient Relationship to Policy Holder: __Self __Spouse __Child __Other (specify) _________
Policy Holder Name (First) _________________ (MI) ____ (Last) _______________________
Policy Holder DOB __ __ /__ __ /__ __ __ __ Policy Holder Sex: __M __F

SECONDARY INS________________________________ Eff Date __ __ /__ __ /__ __ __ __
Claims Address ____
ID# ______________________________________ Group# ____________________________
Patient Relationship to Policy Holder: __Self __Spouse __Child __Other (specify) _________
Policy Holder Name (First) _________________ (MI) ____ (Last) _______________________
Policy Holder DOB __ __ /__ __ /__ __ __ __ Policy Holder Sex: __M __F

ADDITIONAL COVERAGE? __ No __ Yes (If "Yes," please request an additional form)

FINANCIAL RESPONSIBILITY

(Information for a financially responsible parent/guardian is required for all patients under 18 years of age.)

NAME (First) ___________________ (MI) _____ (Last) ______________________________
DOB __ __ /__ __ /__ __ __ __ Social Security# __ __ __ - __ __ - __ __ __ __ Sex: __M __F
Street Address ____
City ____ State ___________ Zip __ __ __ __ __
Home Phone (__ __ __) __ __ __ - __ __ __ __ Cell Phone (__ __ __) __ __ __ - __ __ __ __
Email _________________________ @ ________________ Rel. to Patient _______________

I hereby authorize treatment. I authorize the release of any and all medical information necessary to process my medical claims. I understand that my medical insurance is a contract between myself and my insurance carrier, and not between the insurance carrier and the doctor, and that I am ultimately responsible for all fees incurred during my care and/or the care of my dependents.

I hereby authorize Allergy & Asthma Care, Inc. to apply for benefits to be paid on my behalf for services rendered by their doctors and staff. I assign all benefits directly to Allergy & Asthma Care, Inc. I certify that the information I have reported above is correct and true. I permit a copy of this authorization to be used in place of the original.

Date __ __ /__ __ /__ __ __ __ **Signature**____
(Please note: if patient is minor child, parent/guardian must sign)

PATIENT HISTORY

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR VISIT

Name: ____
DOB: ____
Primary Care Doctor: ________________________________
Referred by: _______________________________________

Welcome. What brings you to see us today? ____
____

When did you take your last antihistamine?____

1. ALLERGY / SINUS - Age first noticed _______________

Symptoms - *check all that apply*

	Runny nose		Sinus infections		Ears plugged up		Wheezing
	Congestion		Sneezing		Itchy eyes		Chest tightness
	Itchy nose		Change in taste or smell		Watery eyes		Exercise intolerance
	Post nasal drip		Headaches		Coughing		

List treatments that have helped ____

Treatments that have not helped ____

Triggers - *check all that apply*

	Spring		Cut grass		Exercise		Cleaning agents/bleach
	Summer		Raking leaves		Laughter		Cigarette smoke
	Fall		Other outdoor activities		Stress		Perfumes and odors
	Winter		Moldy places		Menstruation		Foods
	Year round		Dust		Pregnancy		Medications
	Weather changes		Animals/pets		Alcohol		Colds/viruses

2. ASTHMA - Age at first diagnosis ____________________

Symptoms - *check all that apply*

	Cough		Shortness of breath		Throat tightness
	Wheeze		Chest tightness		Chest burning
	Mucous		Chest pain		Other

Number of asthma hospital admissions (total): __________ In the last 12 months: __________
Number of asthma ICU admissions (total): __________ In the last 12 months: __________
Number of courses of oral steroids for asthma (total): __________ In the last 12 months: __________

In the past 4 weeks:
Is your asthma well controlled? Y / N
Have you limited your activity due to your asthma? Y / N
Missed work due to your asthma? Y / N
Woke up at night coughing or with shortness of breath? Y / N
Maximum number of albuterol puffs in one day: __________
Number of days using any albuterol in last month: __________

List treatments that have helped ____

Treatments that have not helped ____

3. ECZEMA - Age first noticed_________________________ **Frequency:**___________________________

Describe the rash: ____

List any triggers: ____

List treatments that have helped: ____

Treatments that have not helped: ____

4. HIVES - Age first noticed___________________________ **Frequency:**___________________________

Describe the rash: ____

List any triggers: ____

List treatments that have helped: ____

Treatments that have not helped: ____

5. FOOD ALLERGIES - *describe below*

Food	Age	Describe Reaction and Treatment

What foods are you currently avoiding?____

6. INSECT STING REACTIONS - *describe below*

Insect	Age	Describe Reaction and Treatment

7. CURRENT MEDICATIONS - *please attach list or list all here*

8. MEDICATION AND LATEX ALLERGIES - *please list all previous reactions to medications/latex*

Medication	Age	Describe Reaction

9. OTHER MEDICAL HISTORY - *check all that apply*

	High blood pressure		Diabetes/sugar		Thyroid		Other
	Reflux/heartburn		Kidney problems		Cancer		
	Pneumonia		Heart disease		Hepatitis or HIV		

Please list all surgeries and other medical problems: ____

____

Infections - *number in lifetime; if more than zero, please describe and give dates*

	Pneumonia		Fungal infections		Meningitis
	Sinusitis		Skin infections		Ear infections
	Bronchitis		Sepsis		Other

Immunizations - Up to Date? Y / N (explain)____

Reactions to immunizations, if any: ____

_

Date of last: Tetanus ________________ Flu ________________ Pneumonia ________________

10. FAMILY HISTORY - *if yes, please list family member(s)*

	Asthma		Eczema		Cystic Fibrosis
	Allergies		Hives		Cancer
	Food Allergies		Immune Deficiencies		Other

11. ENVIRONMENTAL HISTORY - *check all that apply*

	House		Basement		Carpeting		Carpet in Bedroom
	Townhouse		Mold or moisture		Wood Floors		Feather/down bedding
	Apartment		Gas Heat		Cats, #		Feather/down pillows
	Condo		Electric Heat		Dogs, #		Dust mite covers
	Mobile home		Central Air		Birds, #		Tobacco Smoke
	City		Window A/C		Other Animals		Other exposures
	Suburb		Wood stove/fireplace				
	Rural		Propane heat				

What is your occupation?____

Who else lives in your home?____

Are there any other exposures you are concerned about? ______________________________________

____

____

Smoking?

	Current	Age first started -	Please list below any household members that smoke
	Quit	Age last quit -	
	Never	Average packs per day -	

12. OTHER SYMPTOMS - *check all symptoms that you have currently*

	Fever		Chest pain		Abdominal pain		Headaches
	Weight Loss		Palpitations		Heartburn		Dizziness
	Weight gain		Rashes		Nausea		Vision changes
	Fatigue		Dry skin		Vomiting		Numbness
	Muscle aches		Blood in urine		Diarrhea		Depression
	Joint pain		Burning		Constipation		Anxiety

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HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help insure that Personal Healthcare Information (PHI) is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers in obtaining patient consent for the uses and disclosures of health care information when carrying out treatment, payment, or other health care operations.

As our patient, you should know that we respect the privacy of your personal medical records and will do all we can to secure that privacy. We strive to take every reasonable precaution to protect it at all times. When appropriate or necessary, we disclose the minimum of information required for the purposes of treatment, payment or other health care operations, and only to those we believe are in need of that information so they can provide the service and care that is in your best interest.

We may also have indirect treatment relationships with you (for example, through laboratories that only interact with physicians and not with patients), and may have to disclose Personal Healthcare Information for the purposes of treatment, payment or other health care operations in those situations. These entities are usually not required to obtain patient consent.

We fully support your access to your personal medical records, which can be provided to you after receipt of a written and signed release request. You also have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), a copy of which can be provided to you by our staff.

You may refuse to consent to the use and disclosure of all or part of your Personal Healthcare Information, but this must be done in writing. If you choose to give unrestricted consent today by signing this document, at any future time you may still revoke consent to, or request restrictions on, the use and disclosure of all or part of your Personal Health Information by notifying us in writing of the change. You cannot, however, revoke actions that have already been taken which relied on this or a previously signed consent. Please also note that, under this law, we have the right to refuse to treat you should you refuse disclosure of your Personal Health Information.

Please sign and date below if you consent to the use and disclosure of your Personal Healthcare Information as outlined above. Thank you.

____ __ __ /__ __ /__ __ __ __

Patient Signature (if under 18 yrs of age, parent/guardian must sign) Date

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PATIENT COMMUNICATION PREFERENCES AND PERMISSIONS

Please Print Legibly – Thank You!

Patient Name ______________________________________ D.O.B. ___ ___ /___ ___ /___ ___ ___ ___

Email Address ____ @ _______________________________

Cell Phone # for texts from Allergy & Asthma Care, Inc. (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Because we value your right to privacy, we would like to know how best to handle our communications with you. We routinely have phone, email, and/or texting contact with patients for the following reasons:

- To schedule and confirm appointments
- To discuss test results
- To respond to patient questions and concerns
- To address billing, insurance, or other patient account issues

In the event we attempt to contact you and you are not available, what would you like us to do? (Please check all that apply.)

_____ **Leave a message on your answering machine/voice mail at:**

Home Phone # (__ __ __) __ __ __ - __ __ __ __ Cell Phone # (__ __ __) __ __ __ - __ __ __ __

_____ **Leave the information with:**

Last Name: _____________________________ First Name: ____________________________

Relationship: ____________________________ Phone #: (__ __ __) __ __ __ - __ __ __ __

Last Name: _____________________________ First Name: ____________________________

Relationship: ____________________________ Phone #: (__ __ __) __ __ __ - __ __ __ __

If one of the above parties contacts us, do we have your permission to discuss your health care and account information with them? _____ Yes _____ No

_____ **Do not leave information about me on an answering machine/voice mail or with another person; leave a name and telephone number and I will return your call.**

By signing this form, you are letting us know how best to keep you informed about issues relevant to your healthcare. If any of the information above changes, you are responsible for notifying us of that change. Please request a new form or provide other written and signed notification at that time.

Signature:______________________________________ Date:_________________________

ALLERGY & ASTHMA CARE, INC.

NOTICE OF FINANCIAL RESPONSIBILITY

If you have health insurance and provided our staff with insurance information prior to your appointment, we will attempt to verify your eligibility, copay, and deductible status before you arrive at our office.

Based on the information obtained from your insurer, **you will be asked to pay one or more of the following on the day of your visit**:

- **Any applicable specialty care copay(s).**
- **Any applicable coinsurance percentage for all non-copay services** if your deductible has been met.
- **A 20% down payment, where applicable, for all non-copay services** if your deductible has not been met.
- **The total amount due for services already deemed "non-covered"** by your insurance.

Please note that any payment amounts requested and/or collected at the time of service are estimates only and based on the information provided to us at the time your eligibility is verified. Verification of eligibility does not guarantee insurance coverage or reimbursement for specific services. **Your total payment responsibility will not be determined until your insurer has processed your claim in accordance with the benefits available for the date of your visit.**

If you still have a balance due after your insurance has paid their portion, you will receive a monthly bill until the balance is paid in full. If you overpaid at the time of service, any credit on your account will be applied to other outstanding charges where applicable or refunded to you.

If you do not have health insurance, you will be responsible for all charges incurred during your visit. If you cannot pay in full at the time of service, please speak to our staff to make the necessary payment arrangements prior to your appointment.

Please complete and sign the following:

Patient Name: (First) ___________________ (MI) ____ (Last) __________________________

Date of Birth: __ __ /__ __ /__ __ __ __

I understand that all services provided by the doctors and staff of Allergy & Asthma Care, Inc. will be charged to my account and billed to my insurer(s) and/or to me where applicable.

I understand that it is my responsibility to know and understand my health insurance benefits, and also my right to refuse or postpone any recommended or offered services for any reason. This includes questions or concerns about my insurance coverage for those services, their ultimate cost to me, and/or my ability and willingness to pay that cost.

I understand that by receiving services without explicitly exercising that right I am accepting financial responsibility for all balances due to Allergy & Asthma Care, Inc. and will be billed accordingly.

Date __ __ /__ __ /__ __ __ __ Signature____

(Please note: if patient is minor child, parent/guardian must sign)

APPOINTMENT REMINDERS

Day of your Appointment:

- Set aside approximately **3 hours** for your visit.
- **Eat prior** to your appointment.
- **Arrive 15 minutes prior** to your scheduled appointment time.
- **Bring completed Patient Information and Patient History forms**.
- **Bring completed Patient Communication and Financial Responsibility forms**.
- **Bring all applicable Insurance Card(s)**.

Prior to your Appointment:

- **DO NOT STOP** taking your **ASTHMA MEDICATIONS**.
- **Seven days prior** to your appointment, **discontinue** taking any medications containing **antihistamines**.

  Examples of antihistamines:

  Cold & Sinus Medicines
  Benadryl
  Claritin
  Zyrtec
  Allegra

Helpful information to bring to your appointment:

- **List of medications** you are taking
- **Records** pertaining to your visit concerning allergies or asthma
- **List of questions** you have for the doctor
- **Name/Address** of other physicians you see

Clothing:

- **Skin tests** may be applied to your lower arms; if possible, please wear short sleeves.

Payment and Billing:

- We accept **Cash, Check, MasterCard, Visa** and **Discover**.
- If you have an outstanding balance on your account, you will receive a monthly statement until your balance is paid in full. Statement notifications will be sent electronically (eBill) if a verified email address has been provided for your account.
- For general questions about insurance and billing, you can contact our **Billing Office** at **billing@allergy-asthmacare.com** or by phone at **513.671.0799** or **800.543.1314**. For specific information regarding your personal health insurance benefits, please contact your insurer directly.

We look forward to providing you with quality healthcare.

John Seyerle, M.D. **Ashish Mathur, M.D.** **Allergy & Asthma Care, Inc. Staff**