



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:

**Springdale Office
422 Ray Norrish Drive #2
Cincinnati, Ohio 45246
(phone) 513.671.6707
(fax) 513.671.6710**

You can visit our website at www.allergy-asthmacare.com. Please call 513.671.6707 with any questions or concerns.

Springdale

422 Ray Norrish Dr. #2
Cincinnati, OH 45246
513.671.6707

Clifton

2055 Reading Rd. #150
Cincinnati, OH 45202
513.861.2323

Anderson

8000 Five Mile Rd. #315
Cincinnati, OH 45230
513.624.6600

Kenwood

4760 E. Galbraith #107
Cincinnati, OH 45236
513.791.1143

Richmond, IN

4718 National Rd. E
Richmond, IN 47374
765.966.0390

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

Name: _____

DOB: _____

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

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

<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	Sinus infections	<input type="checkbox"/>	Ears plugged up	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Congestion	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	Itchy eyes	<input type="checkbox"/>	Chest tightness
<input type="checkbox"/>	Itchy nose	<input type="checkbox"/>	Change in taste or smell	<input type="checkbox"/>	Watery eyes	<input type="checkbox"/>	Exercise intolerance
<input type="checkbox"/>	Post nasal drip	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	

List treatments that have helped _____

Treatments that have not helped _____

Triggers - check all that apply

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

2. ASTHMA - Age at first diagnosis _____

Symptoms - check all that apply

<input type="checkbox"/>	Cough	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Throat tightness
<input type="checkbox"/>	Wheeze	<input type="checkbox"/>	Chest tightness	<input type="checkbox"/>	Chest burning
<input type="checkbox"/>	Mucous	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	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



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



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