



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:**

**Anderson Office
8000 Five Mile Road #310
Cincinnati, Ohio 45230
(phone) 513.624.6600
(fax) 513.624.6722
www.allergy-asthmacare.com**

Please call 513.624.6000 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 #310
Cincinnati OH 45230
513.624.6600

Kenwood
4760 E Galbraith Rd #107
Cincinnati OH 45236
513.791.1143

Richmond
4718 National Rd E
Richmond IN 47374
765.966.0390

ALLERGY & ASTHMA CARE, INC.

New patients: complete all sections. Established patients, check all that apply: Insurance change Other change
Please print legibly and present this completed form to the receptionist with your insurance card(s).

PATIENT NAME (First) _____ (MI) _____ (Last) _____
SSN _____ - _____ - _____ DOB ____/____/____ Sex M F
Street Address _____
City _____ State _____ Zip _____
Landline Ph (_____) _____ - _____ Cell Ph (_____) _____ - _____
Email _____ @ _____
Marital Status Single Engaged Married Separated Divorced Widowed
Primary Dr _____ Referring Dr _____
Pharmacy _____ Pharm Ph (_____) _____ - _____

HEALTH INSURANCE? No Yes (If "Yes," all information requested below is required to file your claims.)

PRIMARY INS _____ Eff Date ____/____/____
Claims Address _____
Ins ID# _____ Group# _____
Patient Rel 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 _____
Ins ID# _____ Group# _____
Patient Rel to Policy Holder Self Spouse Child Other (specify) _____
Policy Holder Name (First) _____ (MI) _____ (Last) _____
Policy Holder DOB ____/____/____ Policy Holder Sex M F

Additional medical coverage? No Yes (If "Yes," please request another form.)

FINANCIAL RESPONSIBILITY **Self** (If "Self," skip to bottom to date and sign. Patient must be 18 years of age or older to select this option.)
 Other (Required if patient is under 18 years of age. Please complete the section below.)

NAME (First) _____ (MI) _____ (Last) _____
DOB ____/____/____ SSN _____ - _____ - _____ Sex M F
Street Address _____
City _____ State _____ Zip _____
Landline Ph (_____) _____ - _____ Cell Ph (_____) _____ - _____
Email _____ @ _____ Rel to Patient _____

I hereby authorize treatment, and also the release of any and all HIPAA-protected information required to process this patient's medical claims. I authorize Allergy & Asthma Care, Inc. to apply for benefits to be paid on this patient's behalf for services rendered by their doctors and staff, and assign all benefits directly to Allergy & Asthma Care, Inc. I understand that healthcare insurance is a contract between the insured and the insurance company, and not the insurance company and the doctor, and agree that I am ultimately responsible for all fees incurred during the care of the patient noted above. I certify that the information I have reported above is correct, current, and true, and agree that a copy of this authorization may be used in place of the original.

Date ____/____/____ **Signature** _____
(For patients under 18 years of age, parent/guardian must sign.)

PATIENT HISTORY

Please bring this completed form with you on the day of your visit.

Name _____ DOB ____/____/_____
Primary Care Dr _____
Referring Dr _____

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

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 / 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 first diagnosed _____

Symptoms (check all that apply):

- | | | | |
|---------------------------------------|--|-------------------------------------|--|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Mucous | <input type="checkbox"/> Chest tightness |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Throat tightness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chest burning |
| <input type="checkbox"/> Other: _____ | | | |

Number of asthma-related hospital admissions: Total _____ In the last 12 months _____

Number of asthma-related 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 four weeks:

- | | |
|---|--|
| Has your asthma been well controlled? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you limited your activity due to asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you missed work due to asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you woken up at night coughing or short of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Number of days you used albuterol _____ Maximum number of albuterol puffs in one day _____

Treatments that have helped: _____

Treatments that have not helped: _____

3. ECZEMA: Age first noticed _____ Frequency _____

Describe rash: _____

Triggers: _____

Treatments that have helped: _____

Treatments that have not helped: _____

4. HIVES: Age first noticed _____ Frequency _____

Describe rash: _____

Triggers: _____

Treatments that have helped: _____

Treatments that have not helped: _____

5. FOOD REACTIONS

<u>Food</u>	<u>Age</u>	<u>Reaction and treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What foods are you currently avoiding? _____

6. INSECT STING REACTIONS

<u>Insect</u>	<u>Age</u>	<u>Reaction and treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. CURRENT MEDICATIONS: Please list all medications you are currently taking, or attach a list.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. DRUG / LATEX ALLERGIES

<u>Drug</u>	<u>Age</u>	<u>Reaction</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. OTHER MEDICAL HISTORY (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes / sugar | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Reflux / heartburn | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis / HIV |
| <input type="checkbox"/> Other: _____ | | |

List all surgeries and other medical problems / procedures: _____

Infections: note number in lifetime. If more than zero, please describe and give dates below.

- | | | |
|----------------------|-----------------------|----------------------|
| # <u>Type</u> | # <u>Type</u> | # <u>Type</u> |
| ___ Pneumonia | ___ Fungal infections | ___ Meningitis |
| ___ Sinusitis | ___ Skin infections | ___ Ear infections |
| ___ Bronchitis | ___ Sepsis | ___ Other: _____ |

Description / dates: _____

Are your immunizations up to date? Yes No (if "No," explain below)

Reactions to immunizations, if any: _____

Dates of last immunizations for: Tetanus _____ Flu _____ Pneumonia _____

10. FAMILY HISTORY OF... (if checked, please list family members)

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Eczema _____ | <input type="checkbox"/> Cystic Fibrosis _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Hives _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Food allergies _____ | <input type="checkbox"/> Immune Deficiencies _____ | <input type="checkbox"/> Other (specify below) |

11. ENVIRONMENTAL HISTORY (check all that apply)

- | | | | |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> House | <input type="checkbox"/> Basement | <input type="checkbox"/> Carpeting | <input type="checkbox"/> Carpet in bedroom |
| <input type="checkbox"/> Townhouse | <input type="checkbox"/> Mold / moisture | <input type="checkbox"/> Wood floors | <input type="checkbox"/> Feather/ down bedding |
| <input type="checkbox"/> Apartment | <input type="checkbox"/> Gas heat | <input type="checkbox"/> Cats: how many? _____ | <input type="checkbox"/> Feather/ down pillows |
| <input type="checkbox"/> Condo | <input type="checkbox"/> Electric heat | <input type="checkbox"/> Dogs: how many? _____ | <input type="checkbox"/> Dust mite covers |
| <input type="checkbox"/> Mobile home | <input type="checkbox"/> Central air | <input type="checkbox"/> Birds: how many? _____ | <input type="checkbox"/> Tobacco smoke |
| <input type="checkbox"/> City | <input type="checkbox"/> Window A/C | <input type="checkbox"/> Other animals (list below) _____ | <input type="checkbox"/> Other exposures (list below) _____ |
| <input type="checkbox"/> Suburb | <input type="checkbox"/> Wood stove / fireplace | _____ | _____ |
| <input type="checkbox"/> Rural | <input type="checkbox"/> Propane heat | _____ | _____ |

What is your occupation? _____

Who else lives in your home? _____

Are there any other exposures you're concerned about? No Yes (specify below)

Smoking?

- | | | |
|------------------------------------|--------------------------|---|
| <input type="checkbox"/> Currently | Age first started: _____ | Avg packs/day: _____ |
| <input type="checkbox"/> Quit | Age last quit: _____ | List household members who smoke: _____ |
| <input type="checkbox"/> Never | _____ | |

12. OTHER SYMPTOMS (check all that currently apply)

- | | | | |
|---------------------------------------|---|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Rashes | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vision changes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Burning | <input type="checkbox"/> Constipation | <input type="checkbox"/> Anxiety |



HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help ensure 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.

Date ___ / ___ / ___

Signature _____

(For patients under 18 years of age, parent/guardian must sign.)

ALLERGY & ASTHMA CARE, INC.

PATIENT COMMUNICATION PREFERENCES AND PERMISSIONS

Please print legibly and return completed form to the receptionist.

Patient Name (First) _____ (MI) _____ (Last) _____

Patient DOB ___ / ___ / _____

Because we value your right to privacy, we need to know your preferences regarding our communications with you. We routinely call our patients for a variety of reasons, including the following:

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

If we need to speak with you and you aren't available, what would you like us to do? (Please check all that apply.)

Do not leave information for or about me in an answering machine or voice mail message, or with another person. Leave a name and number and I'll return your call. (If you selected this option, please skip to the bottom to date and sign.)

Leave the information on my answering machine/voice mail at my landline phone number:

Landline Ph (___ ___) _____ - _____

Leave the information on my voice mail at my cell phone number:

Cell Ph (___ ___) _____ - _____

Leave the information with or for any/all of the following contacts:

1. Relationship _____ Emergency contact only

Name (First) _____ (Last) _____

Landline Ph (___ ___) _____ - _____ Cell Ph (___ ___) _____ - _____

2. Relationship _____ Emergency contact only

Name (First) _____ (Last) _____

Landline Ph (___ ___) _____ - _____ Cell Ph (___ ___) _____ - _____

3. Relationship _____ Emergency contact only

Name (First) _____ (Last) _____

Landline Ph (___ ___) _____ - _____ Cell Ph (___ ___) _____ - _____

4. Relationship _____ Emergency contact only

Name (First) _____ (Last) _____

Landline Ph (___ ___) _____ - _____ Cell Ph (___ ___) _____ - _____

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

Thank you for telling us 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.

Date ___ / ___ / _____

Signature _____

(For patients under 18 years of age, parent/guardian must sign.)

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** _____
(For patients under 18 years of age, 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 before** your appointment, **stop** 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.
- **Medical records** pertaining to your visit concerning allergies or asthma.
- **List of questions** you have for the doctor.
- Names/addresses 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, payment, and billing, you may 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.