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
www.allergy-asthmacare.com

Please call 513.671.6707 with any questions or concerns.

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):

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

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 / odors
☐ Winter	☐ Moldy places	☐ Menstruation	☐ Foods
☐ Year round	☐ Dust	☐ Pregnancy	☐ Medications
☐ Weather changes	☐ Animals / pets	☐ Alcohol	☐ Colds / viruses

2. ASTHMA: Age first diagnosed _____

Symptoms (check all that apply):

☐ Coughing	☐ Shortness of breath	☐ Mucous	☐ Chest tightness
☐ Wheezing	☐ Throat tightness	☐ Chest pain	☐ Chest burning

☐ 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? ☐ Yes ☐ No

Have you limited your activity due to asthma? ☐ Yes ☐ No

Have you missed work due to asthma? ☐ Yes ☐ No

Have you woken up at night coughing or short of breath? ☐ Yes ☐ 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

Food	Age	Reaction and treatment

What foods are you currently avoiding? _____

_____

6. INSECT STING REACTIONS

Insect	Age	Reaction and treatment

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

8. DRUG / LATEX ALLERGIES

Drug	Age	Reaction

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

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

☐ Other: _____

List all surgeries and other medical problems / procedures: _____

_____

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

#	Type	#	Type	#	Type
___	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)

☐ Asthma _____ ☐ Eczema _____ ☐ Cystic Fibrosis _____
☐ Allergies _____ ☐ Hives _____ ☐ Cancer _____
☐ Food allergies _____ ☐ Immune Deficiencies _____ ☐ Other (specify below)

_____

11. ENVIRONMENTAL HISTORY (check all that apply)

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

☐ Currently Age first started: _____ Avg packs/day: _____
☐ Quit Age last quit: _____ List household members who smoke: _____
☐ Never _____

12. OTHER SYMPTOMS (check all that currently apply)

☐ 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 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 discuss lab or test results
- To respond to patient questions and concerns
- 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.)

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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.

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