Account # ___________________ Insurance Code: ___________________

ALLERGY AND ASTHMA CONSULTANTS, P.C.

Suite 325
5555 Peachtree-Dunwoody Road
Atlanta, Georgia 30342-1712
(404) 255-9286
Fax: (404) 250-0740

Suite 250
3275 Market Place Blvd.
Cumming, Georgia 30041
(770) 889-8636
Fax: (770) 844-7565

Building 600, Suite 620
11660 Alpharetta Highway
Roswell, Georgia 30076
(770) 740-9600
Fax: (770) 740-9306

Building A, Suite A
3400 McClure Bridge Rd.
Duluth, Georgia 30096
(770) 813-0254
Fax: (770) 813-0255

We appreciate the confidence you have expressed by selecting us as your physicians. If you have any questions about our services, fees, or other aspects of your care, please discuss them with us frankly. The best medical service is based on a friendly, mutual understanding between a doctor and his patients. Our office phone number is also our night and emergency phone. It is answered by our answering service when the office is closed. All patients are expected to pay for your portion of the bill including any copays and/or deductible. At the end of the month, you will receive an itemized statement showing the transactions of your account and the amount due, if any. If you are unable to pay your bill, please contact us and we will assist you in making arrangements for payment. If you are having temporary financial problems, let us know and we will be most understanding and cooperative.

Email Address: ____

Pharmacy # ___________________________ Today's Date ___________________

PATIENT DATA

Mr.
Mrs.
Miss (Please Circle One)
Ms.
Patient Name: M.D. / Ph.D ____ Sex: ______

Address: ____ Age: ______

City: ___________________________ State: ________________ Zip: ______________

Date of Birth: ________________ Marital Status: ________________ Social Security # ________________

Home Phone # ________________ Work Phone # ________________ Cell Phone # ________________

Referred by and Services Requested by Dr. ____

Employer / School Name: ___________________________ Occupation: ________________

Address: ____

Personal Physician: ___________________________ Other Physicians: ________________

Whom May We Thank for Referring You if not a Physician? ___________________________

Address ____

We will be sending a report to your referring physician.
Please list any other physician(s) & address(es) to whom you would like a report of this visit sent. ________________

____

Has Any Member of Your Family Been Treated by Our Physicians? ___________________________

Name ___________________________ Relationship ___________________________

OVER

* Whom Should We Contact in the Event of an Emergency?

Name:____ Phone #(s) (___)_______________

Phone #(s) (___)_______________

SPOUSE INFORMATION

Spouse's Name:____

Business Address:_____________________________ Business Phone:_______________

Employer: _____________________________ Position Held:_______________

GUARANTOR DATA

(Person Responsible for Bill if other than Self)

Name:_____________________________ Relationship to Patient:_______________

Address: ____

City:_____________________ State:_______________ Zip:_______________

Date of Birth: _____________________ Social Security Number:_______________

Home Phone #_____________________ Work Phone # _______________

Employer Name: ____

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(1) **I authorize** the release of a report of diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to treatment, to the physicians listed, also any medical information may be sent to my insurance company.

_____________________________ Signature _____________________________ Date

(2) **Please sign** below to allow medical benefits to be paid directly to Allergy and Asthma Consultants, P.C.

_____________________________ Signature _____________________________ Date

(3) **Our office** will make every effort to comply with your insurance company's rules regarding our referring you or obtaining X-rays and laboratory studies. Due to our participation in over 30 different plans, each with its own regulations (and several companies have several different plans, of which all are different from each other), **WE CANNOT ASSUME ANY FINANCIAL RESPONSIBILITY FOR ERRORS.** It is your responsibility to know what your plan covers and what it does not cover.

_____________________________ Signature _____________________________ Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(This form applies only to the use, release and disclosure of information. It is not consent for treatment or intended for any other purpose.)

By signing this form, I consent to the use and release of all or any portion of the information obtained by Allergy and Asthma Consultants, P.C., as part of medical services provided to me for purposes of:

- **Diagnosis, treatment and care** (including information disclosed to appropriate personnel at Allergy and Asthma Consultants, P.C; other physicians, including those at other medical practices; laboratories; diagnostic centers; hospitals, other health care professionals, facilities and providers etc.
- **Obtaining Payment for Health Care Services** (filing insurance claims, collections, etc.)
- **Health care Operations** (this is a term used in federal privacy protection legislation that relates to quality control and review, business operations, general administrative purposes, and compliance with state and federal laws, etc.)

This consent for use/disclosure of protected health information does not apply to disclosure for other purposes, in which case Allergy and Asthma Consultants, P.C. will obtain specific authorization from me. There are a few exceptions in the law permitting use/disclosure of information without my authorization. Please see the *Notice of Privacy Practices* for details.

I understand that Allergy and Asthma Consultants, P.C. assumes no responsibility for the use or misuse *by others* of my health information disclosed under this consent.

I have been offered the opportunity to review Allergy and Asthma Consultants *Notice of Privacy Practices*. I have discussed any concerns that I may have about the use/disclosure of my health information with the Privacy Officer at Allergy and Asthma Consultants, P.C., or other appropriate personnel.

I release Allergy and Asthma Consultants, P.C. from all legal liability that may arise from this consent specifically with regard to the way my information is used by entities other than Allergy and Asthma Consultants, P.C. *provided that my information is utilized only as outlined above.*

Patient Signature: ______________________________ Date: ______________

If the signature above is not that of the patient, I am acting for them because

____.

My relationship to the patient is: ______________________________________

Signed: ______________________________ Date: ______________

PLEASE SEE REVERSE SIDE

OPTIONAL

You MUST complete this form in order for us to discuss your health/billing information with anyone other than you.

HIPAA Authorization Form For Family Members/Friends

I, ______________________________________ give permission to Allergy and Asthma Consultants, PC to disclose and release my protected health information described below to:

Name(s): Relationship:

____

____

____

Health Information to be disclosed (Check all that apply)

__ My complete health record, including but not limited to diagnoses, lab tests, prognosis, treatment and billing for all conditions) OR

__ My complete health record, as above, with the exception of the following information:

- __Mental health information
- __ Communicable diseases including HIV/AIDS
- __ Alcohol/Illegal drug information
- __Other (please specify) ______________________________________

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options for treatment, or consultation, for claims payment purposes and billing.

This authorization shall be effective until (check one)

- __ all past, present and future periods OR
- __ Date or event

unless I revoke it, which I may do at any time.

Name of patient: ____________________________ Date: _________________

Signature of person giving this authorization if not patient: _________________________

Relationship to patient: ______________________ Date: _________________

Allergy & Asthma Consultants, P.C.

Date	Name	Age	Race	Sex

Referred By:	Primary Physician:	Date of Birth

My main concern and the main reason I am here is:	Date of Onset of Symptoms

SYMPTOMS: Please mark all of the boxes that apply to you

___ Itchy Eyes ___ Watery Eyes
___ Red Eyes ___ Burning Eyes
___ Stuffy Nose ___ Itchy Nose
___ Sneezing - How many times in a row?___________
___ Runny Nose ___ Mucus in Throat
___ Frequent Nose Bleeds
___ Mouth Breathing ___ Snoring
___ Headaches ___ Pressure in Sinuses
___ Sinus Infections ___ Nasal Polyps
___ Pressure in Ears ___ Ear Infections

___ Cough: ___ Frequent ___ Productive of Sputum
___ Wheeze ___ Chest Tightness
___ Shortness of Breath ___ Exercise Limitation
___ Chest symptoms wake me up at night
___ Skin Rash
___ Itching ___ Eczema ___ Hives
___ Indigestion or Heartburn ___ Swelling
___ Rubber or Latex Allergy

PLEASE MARK THE SEASONS WHEN THE SYMPTOMS OCCUR:

	Nose/Hay Fever	Sinus	Eyes	Chest/Asthma	Skin/Eczema or Hives	(Leave Blank)
Year Round						
Spring						
Summer						
Fall						
Winter						

TRIGGERS: Please mark the things that make the symptoms Worse.

	Nasal Sinus	Eye	Chest	Skin		Nasal Sinus	Eye	Chest	Skin
Dusting or Vacuuming					Changes in Weather				
Cats					Changes in Temperature				
Dogs					Cigarette Smoke				
Other Animals					Odors & perfume				
Foods					Cold Air				
Cut Grass					Air Conditioning				
Raked Leaves					Emotional Upset or Crying				
Hay					Exercise				
Dampness					Pregnancy or Menstruation				
Basements					Work or School				
Wet Weather					Other___________				

NAME:______________________ FILE #:__________ DOB:__________

QUALITY OF LIFE: Please mark all that apply

___ Increased fatigue or lack of pep or energy
___ Affects work or school performance
___ Keeps me up at night
I feel less like exercising
___ Cause me to accomplish less than I us I would like to
___ I miss work or school due to my problem
___ This makes me nervous, irritable or unhappy
___ I get sick more than I should

PREVIOUS ALLERGY TESTING AND TREATMENT

Have you ever been Allergy Skin tested? ___Yes ___No Results of Testing __________
When and Where? __________ Did you receive Allergy Injections? ___Yes ___No
What were the effects of injections on symptoms? ___Improved ___No Change ___Worsened ___Side Effects __________

What Other Health Problems Do You Have? Please check and circle all that apply	Review Of Symptoms This column for Physicians Only Yes	No
___ Constitutional: Fatigue, Fever, Weight Loss, Other	___	___
___ Cancer: type __________	___	___
___ CV: Heart Disease, High Blood Pressure, Murmurs, Other	___	___
___ Endocrine Diabetes, Thyroid, Other	___	___
___ Ears-Nose-Throat: Sleep Apnea, Snoring, Other	___	___
___ Eyes: Cataracts, Glaucoma, Other	___	___
___ GI: Hepatitis, Hiatel Hernia, Irritable Bowel, Reflux, Ulcer, Other	___	___
___ Genito-Urinary: Bladder Infections, Kidney Disease, Other	___	___
___ Hematological (Blood): Anemia, Sickle Cell, Other	___	___
___ Musculo-Skeletal: Arthritis, Fibromyalgia, Other	___	___
___ Neurological: Epilepsy, Headache, Seizures, Strokes, Other	___	___
___ Psych: Alcohol or Drug Abuse, Anxiety, Depression, Other	___	___
___ Reproductive: Menopause, Other	___	___
___ Resp: COPD, Emphysema, Pneumonia Tuberculosis, Other	___	___
___ Skin: Eczema, Rashes, Other	___	___
___ HIV, Aids	___	___

MEDICATIONS: Please list all Prescription and Over the Counter Medications you are now taking.

Medication	Dose (mg)	How Often	Medication	Dose (mg)	How Often

Vitamins, Herbs and Other Supplements: Please list all that you are taking.

____

Previous X-Rays

Have you had a Chest X-Ray? ___Yes ___No If Yes, When? __________ Where? __________
Have you had a Sinus X-Ray? ___Yes ___No If Yes, When? __________ Where? __________

HOSPITALIZATIONS OR SURGERIES: Please list all.

Problem or Operation	Age or Date	Problem or Operation	Age or Date

NAME:______________________________ FILE #:__________ DOB:__________

DRUG ALLERGIES: Please list all that apply to the patient		
Drug	Reaction	Date/Year

INSECT ALLERGIES: Please list all that apply to the patient		
Insect	Reaction	Date/Year

FOOD ALLERGIES: Please list all that apply to the patient		
Food	Reaction	Date/Year

FAMILY HISTORY: Please list all that apply						
	Hay Fever	Sinus	Asthma	Eczema	Hives	Other (Leave Blank)
Father						
Mother						
___Sisters ___Brothers						
Grandparents (Father's)						
Grandparents (Mother's)						
Children: ___Male #_____; ___Female #_____						

SOCIAL HISTORY: Please mark all that apply Occupation______________________

Do You Smoke? ___Yes ___No How many packs-per-day _______, for how many years __________

Have you ever smoked in the past? ___Yes ___No How many packs-per-day ______, how many years__________

If you smoked in the past, when did you quit?______________ Other smokers in the home? ___Yes ___No

ENVIRONMENTAL SURVEY: PLEase check all that apply.

How long have you lived in Georgia?__________ Where else have you lived?______________________

Your Home: ___Single Family Home ___Multiple Family Dwelling ___Apartment ___Mobile Home

The HOME	Age of House	How Long Living In Home	Heating System (type)	Type of Filter	Frequency of Filter Charge
	Air Conditioning __Central __Room	Attic Fan __Yes __No	Is Fan Used __Yes __No	Humidifiers __Yes __No	Areas of Dampness, Mold or Mildew __Yes __No Location__________

PATIENT'S BEDROOM	Shared __Yes __No Carpeted __Yes __No	Bedding: __ Innerspring __ Waterbed	Age of Bedding ________ yrs. Allergy Covers __Yes __No	Comforter __ Down __ Synthetic	Type of Pillows __ Down __ Synthetic	Age of Pillows ________ yrs. Allergy Covers __Yes __No

PETS: Do you have pets IN your home? ___Yes ___No			
	How Many	Allowed in Bedroom?	Describe any symptoms that you have around the pet
Dogs		__ Yes __No	
Cats		__ Yes __No	
Birds		__ Yes __No	
Other __________		__ Yes __No	

Allergy and Asthma Consultants, P.C.
Financial Policy Statement

We are committed to providing the highest level of medical care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement. We are here to help! Please feel free to discuss any aspect of this policy with us.

INSURANCE PARTICIPATION

Our physicians participate with MOST insurance companies. We do NOT participate in BCBS HMO or Kaiser HMO. We strongly suggest that you check with your insurance company to insure that our physicians are participating providers with your network.

PATIENT RESPONSIBILITY

It is the responsibility of the patient to pay his/her co-payment and any unpaid portion of the deductible at the time of service unless other arrangements have been made. Any additional copayments or coinsurance will be billed to the patient as indicated by your insurance carrier. Your insurance company will mail or email you an explanation outlining the services rendered and the portion of the bill that is your responsibility. All patients without insurance must pay in full at the time of service.

DENIED CLAIMS

Our billing staff typically will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, pre-existing conditions or any other matter which may cause a claim to be denied. Should your insurance company pend a claim while awaiting information for our office, we will provide that information to them in a timely manner and await their decision.

LABORATORY CHARGES

Please note that any laboratory services will be billed to your insurance company by the rendering lab. Should you receive any bill from the lab, please contact them directly.

PAYMENT OPTIONS

We offer a variety of payment options. We accept all major credit cards, cash and checks. You may phone our office and pay over the phone. For larger bills, you may pay 25% of the billed balance which will keep your account from going into a past due status. All returned checks are subject to a $30 returned check fee in addition to the original check amount.

REFUNDS

All refunds will be processed in a timely manner once the overpayment amount is discovered. We encourage patients to contact us if you are aware that you have a credit that you would like to be refunded to you and our accounting office will promptly process the refund to you.

RELEASE OF ASSIGNMENT

"I hereby assign all medical benefits to which I am entitled for visits to Allergy and Asthma Consultants, P.C. to Allergy and Asthma Consultants, P.C. directly. I understand that I am ultimately responsible for all charges whether or not covered by insurance. I hereby authorize said assigned to release any information necessary to secure payment on my behalf."

CANCELLATIONS

Any scheduled appointment not cancelled at least 24 hours in advance will be subject to a $50 fee. This charge is not reimbursable by insurance.

Your signature below indicates that you have read and understand this policy and have had any questions that you may have about the policy answered.

Patient/Responsible party ______________________ Date ______________

DOB ______________