Allergy, Sinus & Asthma PROFESSIONALS

NEW PATIENT QUESTIONNAIRE

PATIENT NAME _____ BIRTH DATE (AGE) _____ DATE _____

REFERRED BY _____ PRIMARY CARE DOCTOR _____ HERE TODAY WITH _____

OTHER FAMILY MEMBERS WHO ARE ASAP PATIENTS _____

MAIN REASON(S) FOR TODAY'S VISIT

What are the main reasons for today's visit? _____

When was the first time you had this problem? _____

When did this episode start? _____ How often do episodes recur? _____

What time of day are symptoms worse? (circle) morning noon afternoon nighttime all the time anytime

During which months is it most severe? (circle) Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec all year

Are symptoms worse in certain locations? (circle) home work outside indoors other _____

SUSPECTED CAUSES

trees weeds grass mold dust perfumes scents heat cold weather changes smoke

stress cats dogs other animals _____ foods _____ other _____

How long have you lived in this area? _____ Moved from where? _____ Where did you grow up? _____

REVIEW OF SYMPTOMS Circle any current symptom/description that applies or NS if no symptoms.

GENERAL healthy fever chills night sweats tired weight loss weight gain

NOSE NS congestion decreased sense of smell post nasal drip nasal discharge (runny/thick/clear/discolored)
sneezing snorting rubbing bleeds

SINUS NS infections (past/constant/frequent/occasional) pressure drainage

EARS NS infections (past/constant/frequent/occasional) pressure popping discharge rupture earache hearing loss

EYES NS itchy watery red burning dry swollen eyelids puffy dark circles under eyes

MOUTH NS bad breath gum problems lip swelling pain in teeth grinding itching ulcers tongue swelling

THROAT NS difficulty swallowing sore clearing snoring hoarseness loss of voice post nasal drip swelling

GI NS heartburn vomiting nausea diarrhea constipation cramping bloating

CHEST NS tightness pain palpitations heaviness pressure congestion unable to get enough air

WHEEZING NS daily frequent occasional rare associated with illness/exercise

COUGHING NS constant/frequent/occasional dry deep hacking gasping turning blue productive of mucus

Shortness *of* BREATH NS nighttime with exercise with normal activity at rest

URINARY NS frequency urgency burning pain difficulty urinating

JOINTS NS swollen painful

SKIN NS itching dry rash swelling

NEURO NS dizziness lightheaded sleep disturbance anxiety depressed passing out numbness tremor

HEADACHE NS FREQUENCY constant frequent occasional rare

SEVERITY incapacitating severe moderate minor

NATURE throbbing dull stabbing

LOCATION L/R sided top/back of head between/behind eyes temples forehead

ASSOCIATED SYMPTOMS sound sensitivity light sensitivity nausea vomiting visual changes pain in teeth

ASAP
Allergy, Sinus & Asthma
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PATIENT NAME _____ BIRTH DATE (AGE) _____ DATE _____

MEDICATION HISTORY

CURRENT medications *(prescription, non-prescription, herbal, creams, sprays, pills, liquids, drops)*

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Have you ever been prescribed an EpiPen (adrenalin/epinephrine)? N/Y for _____

What medications have been HELPFUL now or in the past? _____

What medications have been UNHELPFUL? _____

DRUG ALLERGY/INTOLERANCE Describe when/what reaction occurred or None Known

1. _____ _____

2. _____ _____

3. _____ _____

MEDICAL HISTORY

FOOD ALLERGY/INTOLERANCE (circle) None Known Yes, describe when/what reaction occurred _____

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

INSECT REACTIONS: No Yes, describe type insect and nature and location of reaction _____

LATEX ALLERGY: No Yes,

ALLERGY SHOTS: Never Yes When?_____ Where?_____ Who was your doctor? _____

How long did you take shots?_____ Did they help?_____ Date of last skin test? ___ What were you allergic to? _____

Any problems with skin-testing or allergy shots in the past? No Yes, describe _____

OTHER PROBLEMS: *(please circle and describe any that you have now or have had in the past)*

High blood pressure	Reflux	Thyroid problems
Heart attack	Hiatal hernia	Kidney problems
Stroke	Diabetes	Chronic infections
Glaucoma	Emphysema	Skin problems
Cataracts	History of asthma	Lupus/other Autoimmune
Depression	Gout	Liver problems
Bipolar	Arthritis	Cancer of _____
ADD/ADHD	Fibromyalgia	Bleeding problems _____
Osteoporosis/ osteopenia	Other _____	

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PATIENT NAME _____ BIRTH DATE (AGE) _____ DATE _____

HOSPITALIZATIONS/OPERATIONS *(Include dates)*

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ENVIRONMENTAL HISTORY

1. Occupation / grade in school / daycare _____
2. Hobbies _____
3. *IF CHILD* Fullterm Premature*(how early?)* _____ Birth Weight_____ Delivery: Vaginal Caesarean Adopted

   Breast fed: Yes No Complications: before during after birth? _____

   Who has legal custody?_____ With whom does child live? _____
4. Vaccinations current? Yes No
5. Personal tobacco use never yes, onset _____ how many years?_____ packs per day? _____
6. Alcohol use never yes, onset _____ how many years?_____ maximum amount_____ quit _____
7. Recreational drug use never past current _____
8. Any increased HIV risk factors? no not sure yes _____
9. Pets *(type/number)*_____ how long?_____ inside outside both in bedroom

   Do you have increased allergy symptoms around animals? No Yes _____
10. HOME Age of building_____ water damage/leaksvisible mold/musty odor? _____

    Please circle appropriate responses below:

    FLOORING carpet tile hardwood throw rugs other _____

    BEDROOM FURNITURE box spring/mattress waterbed stuffed chair/couch throw pillows

    down pillows and/or comforter tapestries

    WINDOW COVERINGS cloth roll shades shutters wood/metal/plastic blinds

    FANS No, not used Yes, in rooms

    AIR CONDITIONING central window units
11. WORKPLACE/SCHOOL mold animals chemical exposure paint fumes smoke other _____

MEDICAL HISTORY

List family member(s) affected.

1. Allergies_____
2. Sinus problems_____
3. Asthma_____
4. Eczema _____
5. Hives/Angioedema _____
6. Emphysema _____
7. Other diseases that run in the family _____

Please state the general health of the following immediate family members. If deceased, please indicate cause of death. Include sex and age of children and siblings.

Mother_____ Siblings_____

Father_____ Children_____

Spouse _____ _____

SIGNATURE _____ _____

REVIEWED WITH PATIENT/PARENT BY

Allergy, Sinus & Asthma PROFESSIONALS

Patient Information

Patient Name: _____ DOB: _____
First Middle Last

Home Address: _____
City State Zip

Home: _____ Work: _____ Cell: _____

Email: _____ SSN: _____ Race: _____

Sex: Male / Female Ethnicity: Hispanic or Latin Not Hispanic or Latin Refuse to Report

Marital Status: Married Single Divorced Widowed Preferred language: _____

How were you referred to our office? _____

In case of Emergency, Notify:

Name: _____ Relationship: _____ Phone: _____

Primary Insured

Responsible Party Name: _____ DOB: _____
First Middle Last

Home Address: _____
City State Zip

Home: _____ Work: _____ Cell: _____

SSN: _____ Relation to Patient: _____ Employer: _____

Insurance Information

Primary Insurance: _____ ID Number: _____ Group _____

Secondary Insurance: _____ ID Number: _____ Group _____

Miscellaneous Information

Primary Care Physician/Pediatrician _____Phone _____

Pharmacy _____ Cross Street _____ Phone _____

Signature _____ Date: _____

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INSURANCE

Due to the increased requirements of insurance companies, and to help us better serve your needs; please take a few minutes to read our office policy with filing your insurance:

- If your insurance carrier requires a referral from your primary care physician, it is your responsibility to make sure we have the referral in our office before the visit. The office cannot be responsible for obtaining or issuing any referrals. _____PI
- It is your responsibility to provide the office with the correct insurance information before your appointment. If you do not provide the office with the correct insurance information, you will be financially responsible for the services.
- We will make every attempt at the beginning of your health care to receive verification of your policy benefits. The information that we receive from your insurance carrier is only a quote of benefits, not a guarantee of payment. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account immediately. We recommend that you also contact your insurance company to verify the Asthma and Allergy coverage on your policy. _____PI
- It is the patient's responsibility to pay any deductible, co-insurance, and/or co-payments **at the time services are rendered.** If Injections, Allergy Testing, X-Ray, CT scan or other in-office procedures are recommended for your treatment; please be aware that your insurance may or may not apply these procedures to your deductible.
- Our office is pleased to assist you in filing claims with your insurance company for reimbursement of your expenses. We will wait ninety (90) days for your insurance company to pay your claim. If they deny your claim and/or do not pay your claim for any reason, any remaining balance must be paid by you within thirty (30) days. We will not fight your insurance company for payment. We file insurance for you as a courtesy.
- **I understand if I do not give a minimum of 48 hours notice of cancellation/reschedule for any Allergy Testing, New Patient or Xolair appointment, there will be a $50 charge. If I do not give a minimum of 48 hours notice of cancellation/reschedule for any Rush IT appointment, there will be a $100 charge. Failure to cancel/reschedule an Office Visit at least 24 hours prior to my appointment will result in a $30 charge. These charges are not covered by my insurance. _____PI**

I fully understand the above policies and agree to them. I understand that I am responsible for payment to Allergy, Sinus & Asthma Professionals for all charges incurred by myself, regardless of my insurance coverage. Patients with large deductibles and or patients we have had previous collection issues with may be required to leave $250 deposit prior to each visit, or the estimated cost of your visit if its allergy testing, ct scan etc. For your convenience, we accept Cash, Visa, Master Card, Discover, and personal checks (with proper identification) as methods of payment. _____PI

SELF- PAY PATIENTS

Self-pay patients are required to provide a $250 deposit prior to being seen by the provider. Deposits are cash or credit card only. _____PI

CONSENT FOR TREATMENT

I give permission to the physician and whoever may designate as assistant(s)/associate(s) to administer such treatment as is necessary, and to perform any medical care or procedures as are considered therapeutically necessary based on findings during examination or treatment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Allergy, Sinus & Asthma Professionals to release any medical information pertaining to the examination, treatment, history, prescription of medications, and medical expenses of myself to any physician, hospital, clinic, insurance company, and all other agencies deemed necessary in order to process insurance claims. This authorization also includes the release of any pertinent medical information to any specialist or other medical facility the physician may refer the patient to for medical treatment or evaluation.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Allergy, Sinus & Asthma Professionals for services rendered. I understand that I am financially responsible for any co-pays, co-insurance, or deductibles required by my insurance company. I also understand that I am responsible for charges that are not covered by my insurance company.

By my signature I agree to comply with the Financial Policy, Consent for Treatment Policy, Authorization to Release Information Policy, and Assignment of Benefits.

_____

Patient Name/Authorized Person's Name

_____ _____

Insured or Authorized Person's Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.
This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please the Privacy Officer at Allergy, Sinus & Asthma Professionals.

Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of another specialist. When we refer you to another specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

The physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

Example: We may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Example: We may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures.
However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by the Texas workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.

- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the designated record set.
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Chris Hunckler, Practice Administrator
Allergy, Sinus & Asthma Professionals
950 Threadneedle, Suite 160
Houston, Tx 77079
(832) 379-8200

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Allergy, Sinus & Asthma
PROFESSIONALS

Notice of Privacy Rights
Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights which I have reviewed and give my permission to Dr. D. Lynn Dickens to use and disclose my health information in accordance with it.

Please circle which ways we may contact you:
Cell/Text Home Work Email

If you do not give specific permission to speak to your family members, we will assume that you do not want any information relayed to anyone in your household.

Please specify the names of people who you authorize this office to discuss your medical care and test results with if we cannot reach you:

_____

_____

_____ _____

Signature of Patient Signature of Patient's Representative

_____ _____

Name of Patient (Print or Type) Relationship of Representative to Patient

_____ _____

Date Date