ALLERGY & ASTHMA CARE OF INDIANA
CARMEL • INDIANAPOLIS • GREENFIELD
BOARD CERTIFIED IN ALLERGY & IMMUNOLOGY
Treating patients of all ages
GARRICK P. HUBBARD, M.D. JOEL C. SHOUSE, FNP-C ARIANA L. REYNOLDS, PA-C

Dear New Patient:

We would like to welcome you to Allergy & Asthma Care of Indiana and look forward to caring for your allergy needs. We have three office locations; please be certain of the correct location for your appointment.

- 11590 North Meridian Street, Suite 400, Carmel, Indiana 46032
- 227 S Delaware St, Indianapolis, IN 46204
- 300 E Boyd Ave, Suite 207, Greenfield, Indiana 46140

A parent or legal guardian must accompany all minors under 18 years of age. The initial visit to our office will often take 2 hours or more, and any necessary skin testing will most likely be completed during that time. Because we have set aside a significant amount of time for your appointment, if you need to cancel, please do so at least 24 hours in advance.

***It is extremely important that you read the "MEDICATIONS TO HOLD" information at least 10 days prior to your scheduled visit. If you feel you cannot do without your medication(s), please contact our office and discuss this with us*.**

If you are currently taking any medications, please bring these with you. Otherwise, contact your doctor or pharmacist for a complete list of your medications. Please bring pertinent records, labs, and written reports of any imaging studies (x-rays, CT scans) with you.

It is helpful if you wear short sleeves to the appointment. All persons attending the appointment MUST refrain from using perfume and/or cologne on the day of your appointment with us. Also, please do not smoke and try to avoid being around smoke prior to coming into the office, as both of these irritants pose a significant health hazard to many of our patients.

Upon arrival, our receptionist will copy your picture ID and insurance card. We will also file an insurance claim for you. Per our Patient Financial Policy and contractual agreements with your health plan, **you will be required to pay your office visit co-pay at the time of your visit.** To assist you in making this payment, all of our offices accept MasterCard, Visa, American Express, and Discover. Our practice participates in the Medicare Program and with most commercial health insurance plans. However, it is your responsibility to verify with your health plan that the doctor you will be seeing is an enrolled provider**,** as health plan networks change frequently. If you have any questions about our participation in your plan(s), please contact our office. If your insurance requires a written authorization to see a specialist, please contact your primary care physician to obtain the referral PRIOR to your visit. Remember, your insurance agreement is between you and your insurance company. Any unpaid balance will be your responsibility.

Attached below, you will find several forms that we ask that you print and complete. Please bring the completed forms with you, as this will help to speed up your check-in. Please arrive 10-15 minutes prior to your scheduled appointment to allow time for us to process the information for your file. We appreciate your interest in our practice and look forward to helping you with any allergy and/or asthma treatment.

MEDICATIONS TO HOLD FOR SKIN TESTS AND ORAL CHALLENGES

Allergy & Asthma Care of Indiana

STOP 7 or 10 DAYS BEFORE APPT.	STOP 3 DAYS BEFORE APPT.	DO NOT TAKE MORNING OF APPT.	LAST DOSE NIGHT BEFORE APPT.
***Antihistamines/ Cold Meds (7 days):** Allegra (fexofenadine), Alavert, Clarinex (desloratadine), Claritin (loratadine), Xyzal (levocetrizine), Zyrtec (cetirizine), Actifed, AlleRX, Bromfed (brompheniramine), Chlortrimeton, Codimal, Dimetapp, Duratuss, DuraVent, Rynatan, Rynatuss, Semprex-D, StaHist, Tavist (clemastine), Trinalin, Tussicaps, Tussi-12D, Tussionex, Allergy/Sinus meds, Dicel, Palgic, Atarax (hydroxyzine), Phenergan (promethazine) **Eye Drops(7days):** Optivar, Zaditor, Alaway (ketotifen) **Nasal Sprays (10 days):** Astelin, Astepro, Patanase, Dymista	***Antihistamines** Benadryl **Heartburn meds:** Pepcid, Tagamet, Zantac, Axid, **Vertigo/Dizziness Meds:** Antivert (meclizine) **Eye Drops:** Elestat, Pataday, Patanol, Lastacaft. **Over-the-counter pain/sleeping aids with "PM"** ex: Tylenol PM **STOP 7 Days Prior:** ****Irritable Bowel Meds (7days)** **Hysoscyamine (Levsin, Levbid, Anaspaz, etc.)** **Librax** **Donnatel** **Bentyl**	**● Inhalers:** Albuterol, Combivent, Maxair, Proventil, Terbutaline, Ventolin, Xopenex, ProAir Atrovent **●ONLY hold above inhalers IF symptoms allow** **If you have an afternoon appt, refrain from using inhalers after 8:00 am.**	Advair, Foradil, Spiriva, Serevent, Symbicort, Dulera, Breo, Incruse, Anoro, Stiolto. **NO RESTRICTIONS:** **Inhalers:** Alvesco, Asmanex, Flovent, Intal, Pulmicort, QVAR, Arnuity. **Nasal Sprays:** Flonase (fluticasone), Nasacort (triamcinolone), Nasonex, Omnaris, Veramyst, Zetonna, Fluosinolide, QNasl, Rhinocort **Other:** Accolate, Singulair, Theophylline, Zyflo, topical steroid creams such as hydrocortisone cream

***If evaluation is for hives, it is OK to continue antihistamines.**

****MUST** obtain permission from PCP BEFORE discontinuing the following medications; these medications need to be held 7 days OR LONGER.

****Antidepressants, sleeping aids:** doxepin, Elavil (amitriptyline), Norpramin (desipramine), Pamelor (nortriptyline), Surmontil (trimipramine), Vivactil (protriptyline)

If you have any questions, or you feel you cannot go without a medication, please contact us at 317-708-2839.

ENVIRONMENTAL AND SOCIAL HISTORY

Name_____ Date of Birth_____

What is the main concern(s) that brought you here today? _____

HOME:

Do you live in a … ☐ City ☐ Town ☐ Rural Area

Do you live in a … ☐ House ☐ Apartment ☐ Other _____

How long have you lived in your current place of residence? _____years _____months. Age of home?_____

Basement? ☐ Yes ☐ No If yes, is your bedroom in the basement? ☐ Yes ☐ No ☐ N/A

Are any areas of your home… ☐ Damp ☐ Musty ☐ Seepage ☐ Flooding

Do you have Dust Mite/Allergy Covers on the mattress ☐ Yes ☐ No On Pillows? ☐ Yes ☐ No

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PETS: If applicable, please list number of pets and circle where they reside. ☐ No Pets

☐ Dog(s)_____indoor/outdoor ☐ Cat(s)_____indoor/outdoor ☐ Bird_____ ☐ Horse_____ ☐ Other_____

Do your pets go in the bedroom? ☐ Yes ☐ No ☐ N/A

If minor, and split household: please list number of pets and circle where they reside in the 2nd household ☐ No Pets

☐ Dog(s)_____indoor/outdoor ☐ Cat(s)_____indoor/outdoor ☐ Other_____ ☐ N/A

Do pets go in the bedroom at 2nd household? ☐ Yes ☐ No ☐ N/A

SOCIAL HISTORY: ☐ Smoker ☐ Life-long Nonsmoker Exposed to 2nd Hand Smoke? ☐ Yes ☐ No

If Current/Previous Tobacco Use… How long?_____ How much?_____When did you quit?_____

Occupation_____If pertinent, please list any occupational exposures:_____

PAST MEDICAL HISTORY:

Medical problems/diagnoses:_____

_____

Surgical procedures/year:_____

_____

Hospitalizations/reason/year:_____

_____

If patient is a child: Born full term? ☐ Yes ☐ No_____ (# weeks) Any complications? ☐ No ☐ Yes, list:_____

Normal growth? ☐ Yes ☐ No Normal development? ☐ Yes ☐ No Up to date on vaccines? ☐ Yes ☐ No

Is he/she in daycare or preschool? ☐ No ☐ Yes, number of days/week:_____

PREVIOUS MEDICATIONS: Please list any allergy/asthma/reflux medications you have tried in the past, for how long, and response

_____

_____

_____

How many courses of antibiotics have you had in the past year? _____

Have you ever taken prednisone? ☐ Yes ☐ No If yes, how many times in the past year?_____in your life?_____

Name_____ Date of Birth_____

REVIEW OF SYSTEMS (Please check all that apply, or mark "Nl" for normal if there are no problems)

General	☐ Nl	☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Trouble sleeping
Skin	☐ Nl	☐ Rashes ☐ Eczema ☐ Hives ☐ Dry ☐ Sensitive skin ☐ Hair and nail changes
Head	☐ Nl	☐ Headaches ☐ Head injury ☐ Neck Pain ☐ Migraines ☐ Wake up with headache
Ears	☐ Nl	☐ Decreased hearing ☐ Ringing in ears ☐ Earache ☐ Itching ☐ Infections
Eyes	☐ Nl	☐ Itching ☐ Redness ☐ Glasses/contacts ☐ Pain ☐ Vision Loss/Changes ☐ Cataracts ☐ Glaucoma Last eye exam_____
Nose	☐ Nl	☐ "Stuffy" ☐ "Runny" ☐ Itching ☐ Sneezing ☐ Nosebleeds ☐ Sinus pain ☐ Sinus infections ☐ Nasal Polyps
Throat/Voice	☐ Nl	☐ Itching ☐ Dentures ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush ☐ Clearing throat frequently ☐ Post nasal drainage
Lungs	☐ Nl	☐ Cough ☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing ☐ Chest tightness ☐ Asthma ☐ History of Pneumonia ☐ Bronchitis ☐ COPD ☐ Cough during/after exercise
Heart	☐ Nl	☐ Chest pain ☐ Heart disease ☐ Palpitations or skipped beats ☐ Swelling of feet/ankles ☐ Shortness of breath with activity ☐ Waking up from sleep gasping ☐ High cholesterol
Stomach	☐ Nl	☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Rectal bleeding ☐ Nausea ☐ Ulcers ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea
Urinary	☐ Nl	☐ Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine ☐ Incontinence
Joints/Muscles	☐ Nl	☐ Pain ☐ Stiffness ☐ Back/neck pain ☐ Joint swelling ☐ Trauma ☐ Muscle weakness
Neurologic	☐ Nl	☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness ☐ Numbness ☐ Tingling ☐ Tremor
Hematologic	☐ Nl	☐ Ease of bruising ☐ Ease of bleeding ☐ Blood Disorder
Endocrine	☐ Nl	☐ Heat or cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst ☐ Diabetes ☐ Thyroid disorder
Psychiatric	☐ Nl	☐ Nervousness ☐ Stress ☐ Depression ☐ Anxiety
Allergies to…	☐ None Known ☐ Insect stings ☐ Latex ☐ Food ☐ Medication Please list_____	

FAMILY HISTORY: Does anyone in your family have nasal allergies or hay fever?

☐ No ☐ Parents ☐ Siblings ☐ Children ☐ Other_____

Does anyone in your family have food allergies?

☐ No ☐ Parents ☐ Siblings ☐ Children ☐ Other_____

Does anyone in your family have eczema?

☐ No ☐ Parents ☐ Siblings ☐ Children ☐ Other_____

Does anyone in your family have cystic fibrosis?

☐ No ☐ Parents ☐ Siblings ☐ Children ☐ Other_____

Does anyone in your family have COPD (Chronic Obstructive Pulmonary Disease)? If so, at what age were they diagnosed?

☐ No ☐ Parents ☐ Siblings ☐ Children ☐ Other_____

FAMILY MEMBERS: Are any of your family members seen by our practice? Name(s)/Relationship _____

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Date_____

Name_____ _____ _____ _____ Male/Female
Last First Middle Nickname Single/Married

Address_____City_____State_____

Zip_____ Home Phone # ( )_____Cell Phone # ( )_____Preference : Home/Cell

Social Security#_____DOB_____ Email Address:_____

Employer_____Address_____

City _____ State _____Zip _____Work Phone# ( )_____

If patient is a minor, provide Mother's Name _____Father's Name _____

PRIMARY INSURED PARTY INFORMATION

Name_____ Male Female DOB_____
Last First Middle

SS# _____Relationship to Patient _____ Home Phone# ( )_____

Address _____City _____State_____ Zip_____

Employer_____Address_____

City_____ State_____ Zip_____ Work Phone# ( ) _____

SECONDARY INSURED PARTY INFORMATION

Name_____ Male Female DOB_____
Last First Middle

SS# _____Relationship to Patient _____ Home Phone# ( )_____

Address _____City _____State_____ Zip_____

Employer_____Address_____

City_____ State_____ Zip_____ Work Phone# ( ) _____

EMERGENCY CONTACT

Name _____Relationship _____Phone#_____Cell#_____

PRIMARY CARE PHYSICIAN– If none, mark ☐. Otherwise, please provide the following:

Name _____ Address_____Phone #_____

REFERRED BY

Name _____ Address_____Phone #_____

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Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: **Allergy & Asthma Care of IN**

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity who is to receive your PHI):

Individual/Entity Name: _____ Individual/Entity Name: _____

Phone/Fax: _____ Phone/Fax: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.

PATIENT FINANCIAL POLICY

Thank you for choosing us as your specialty health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. Our staff is trained to inform you of the financial policies of this practice. This document must be read and signed by each patient and will remain in effect for all services rendered during your time as a patient in our practice.

INFORMATION: A current registration will be on file in the patient chart during the time that the patient is considered active. Patient registration will be updated yearly and will include numbers for the patient including home phone, cell phone and work phone. A signature by the responsible party is required. On an annual basis, or as needed, we will ask for a photocopy of your insurance card for your file.

Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance carrier unless you give us your insurance information. Failure to provide us with accurate information can result in denied claims, which are then the responsibility of the patient.
AACI is more than happy to call and obtain benefits on your behalf as a courtesy, this is not a guarantee that the insurance company will pay the claim and/or that the benefits are quoted correct buy the insurance company.
AACI recommends that you also call your insurance company and verify your coverage for procedures (e.g. starting Immunotherapy).
The patient is ultimately responsible for charges incurred regardless of the insurance involved.

INSURANCE CLAIMS: I am authorizing Allergy & Asthma Care of Indiana (AACI) to furnish information to insurance carriers concerning the illness or medical treatment of myself or dependents and I hereby assign to the provider all insurance payments for medical services rendered to myself or my dependent, except for those services for which I have already paid prior to the filing of the insurance claim. In addition, I hereby designate AACI as my representative to file grievances and to represent me in accordance with the Indiana Code, title 27, Chapters 8 and 13. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in the responsibility.

Primary Insurance: Allergy & Asthma Care of Indiana (AACI) will file your medical claim upon proof of insurance; (i.e., insurance card). As part of your insurance contract, full payment for ***"your part"*** of the charges is expected from you at the time of service**.** ***"Your part" of charges incurred is defined as any co-pays, deductibles or non-covered service charges that are incurred on the date of service***. Come prepared to pay your co-pay at the time of service. If the patient has insurance coverage but cannot provide documentation, payment is due in full at the time of service.

Please be aware that some, and in rare cases all, of the services provided *may* be non-covered services and not considered payable under your insurance plan. **You need to contact your insurance carrier prior to your appointment for your coverage benefits.** If your insurance carrier requires you to obtain a referral for any office visits, you are responsible for obtaining that referral. If no referral is obtained and/or services rendered are not covered for any other reason, you are still responsible for the payment. We may at times assist in this process, but the full responsibility remains with the patient or responsible party.

Secondary Insurance**:** Claims will be filed with secondary insurance if adequate information is received at the time of service.

PATIENT FINANCIAL RESPONSIBILITY: If no insurance is to be filed by AACI, or if AACI is not a participating provider in your insurance network, and you do not have out-of-network benefits, **full payment is due at the time of service unless other arrangements have been made. If you receive injections and need new vials, your previous vials will need to be paid in full for new vials to be mixed. Please be prepared to pay any co-insurance/co-pays/deductible at the time of each injection.** **over**

A finance charge of 1% (monthly) may be applied to any balance unpaid after 60 days of receipt of insurance payment.

MINORS/DEPENDENTS: Children under the age of 18 will require the signature of a responsible adult party on the registration form. An adult is required to accompany children under the age of 18 to all office visits.

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, Visa, Discover, and MasterCard. Visa, Discover, and MasterCard will be accepted by phone or fax. Any returned check will result in an additional fee of $25.

ACCOUNTS PAST DUE: Payment is due upon receipt of each statement. Non-compliance may result in preparation of account for small claims court, collection agency, and/or credit bureau reporting and possible discharge from the practice.

In the event an account is turned over for collection, the person financially responsible for the account will be responsible for the cost of collections, which includes, but is not limited to, late fees, collection agency fees, court costs, interest, and fines.

A patient may remit in full to the collection agency all outstanding charges owed on account and include amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

CONFIRMATION OF APPOINTMENTS: AACI will usually call you to confirm your office appointment. We will leave a message on your voice mail or with a family member if you are unavailable. This is a courtesy reminder only, and you are still responsible for missed appointments even if a reminder call is not made.

MISSED APPOINTMENTS: Appointments missed and not cancelled prior to 24 hours will be charged a "no show" fee of $25.00. If a **New Patient** misses their appointment and did not cancel prior to 24 hours, no additional appointments will be made. If an established patient misses and/or cancels with less than 24 hours notice four (4) times, the patient may be discharged from the practice.

ACCOUNT CONSULTATION: Our account representative will be happy to discuss your account. If further assistance is needed, our Practice Manager, can be consulted as well.

MEDICAL RECORDS: If you require copy of your records or would like us to transfer your records to another allergist, there will be a $10.00 administrative fee for copying the first 10 pages and .50 for each page thereafter. There may be an additional charge for postage or faxing records. This fee must be paid prior to the transfer of the records. You will also be asked to sign an authorization form for the transfer of records. Should we refer you to another physician; copies of your records will be provided to them at no cost.

DIVORCE DECREES: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Your signature below indicates that you accept and understand this policy. Further, your signature authorizes AACI, to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to AACI when an assigned claim is filed.

I have received a copy of the AACI financial policy.

_____ _____ _____

Print Patient's Name Signature (patient or responsible party) Date

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Acknowledgement of Receipt of the Notice of Privacy Practices

This is to acknowledge my receipt of this facility's Notice of Privacy Practices.

_____ _____
Patient Name Name/Relationship of Personal Representative (if applicable)

_____ _____
Patient's signature Personal representative's signature

_____
Date

If mailing to individual:

Date mailed: _____

Address mailed to: _____

_____

_____

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