First Visit Checklist

Patient Name:_____ Appt Date/Time:____/____/____:____am / pm

Welcome to The Asthma Center! We have put together a few tips and guidelines to make your first appointment as effective as possible. We are looking forward to seeing you in the office for the first time, please don't hesitate to call us if you have any questions!

Center City Philadelphia 215-569-1111 (205 North Broad Street, Ste. 300, Philadelphia, PA 19107)
Northeast Philadelphia 215-677-4433 (2137 Welsh Road, Ste. 2B, Philadelphia, PA 19115)
Langhorne, PA 215-750-7040 (Penn's Square at Oxford Valley, 404 Middletown Blvd., Ste. 305, Langhorne, PA 19047)
Mt. Laurel, NJ 856-316-0300 (2059 Briggs Road, Ste. 306, Mt. Laurel, NJ 08054)

Before Your Visit Checklist

- □ **Fill out** the enclosed New Patient Forms and bring signed Financial Policy and Credit Card Authorization forms.
- □ **Do not** take prescription or over-the-counter antihistamines for the 3 days prior to your first visit as antihistamines can interfere with allergy skin testing.
- □ **Take** asthma medications as usual.
- □ **Ask** questions about medications that may interfere with your testing by calling the office where you are scheduled.
- □ **Prepare** information about:
  - □ Previous diagnosis, treatments, surgeries, heart studies (stress test, echo, calcium score), and testing
  - □ List of current medications
  - □ Copy of recent lab work and/or x-rays
  - □ A proper referral if required by your insurance
  - □ Insurance card and photo ID, which are required for your visit
  - □ Bring your username and password so that you can access your healthcare portal during your visit

Day Of Your Visit Checklist

- □ **Bring** all information prepared above, information about: (1) previous diagnosis, treatments, surgeries and testing (2) list of current medications (3) copy of recent lab work and/or x-rays (often available on a patient portal like myPennMedicine, Virtua MyChart, or Jefferson Health MyChart) (4) proper referral if required by your insurance, (5) insurance card and photo ID, (6) and if using a healthcare app, please make sure you are able to log into your portal during the visit, so that we will be able to retrieve important health records and current medications during your visit.
- □ **Wear** short-sleeve shirt in case allergy skin testing is performed on the upper arm.

What To Expect During Your Visit

First visits often take **2 – 3 hours**, depending on how complicated the medical conditions are and what testing might be needed. You will be seen by one of our nurses and one of our board-certified allergists. The physician will review all your current symptoms, past medical history, environmental exposures, and will conduct a physical examination. Skin testing and/or a breathing test may be concurrently done during this time. We recommend our patients wear a short-sleeve shirt on the day of the appointment in case intradermal allergy skin testing is performed on the upper arm.

Kindly provide at least 48 hour notice to cancel your appointment. Failure to do so will result in a $150 fee
Notice must be provided by direct phone contact (speaking with a member of our staff during business hours).
Notice will NOT BE ACCEPTED by any other means (such as voicemail, email, fax or text messaging)

DATE:_____

The Asthma Center
ALLERGIC DISEASE ASSOCIATES, P.C.

Sec. Initials:

PATIENT NAME: (Last)_____(First)_____

Cell: _____ Home:_____Work: _____

Email:_____

ADDRESS: (Street)_____

(City)_____(State)_____(Zip)_____

Date of Birth:_____ Sex: _____

Emergency Contact Name:_____Phone No.:_____

Family Provider: _____Fax:_____Phone No.:_____

Address: _____(City)_____(State)_____(Zip)_____

Referring Provider: _____Fax:_____Phone No.:_____

Address: _____(City)_____(State)_____(Zip) _____

Other source of referral: _____

Consent for communication on you or your child's health with your provider(s) ☐ Yes ☐ No

Pharmacy Name:_____ Pharmacy Phone No.:_____

PRIMARY INSURANCE

Insurance Name_____

Guarantor*_____

List person or insured name responsible to ensure payment of all covered & non-covered services.

Guarantor DOB_____

ID # _____

Group # _____

Relationship to patient_____

Employer Name _____

Employer Phone # _____

SECONDARY INSURANCE

Insurance Name_____

Guarantor*_____

List person or insured name responsible to ensure payment of all covered & non-covered services.

Guarantor DOB_____

ID # _____

Group # _____

Relationship to patient_____

Employer Name _____

Employer Phone # _____

Medicare and Commercial Insurance Patients:
I authorize the release of any medical information necessary to process all claims and I authorize payment of medical benefits to **Allergic Disease Associates, PC** for services rendered. It is the policy of Allergic Disease Associates PC and the policy of my insurance company that all co-payments be collected at the time of the medical service. There will be a $15 billing charge for each co-payment not paid at the time of service. I have received a copy of the Allergic Disease Associates, P.C. Practice Policies.

Signature: _____

HIPAA Notice of Privacy Practices:
Acknowledgment and Consent Form

The Asthma Center
ALLERGIC DISEASE ASSOCIATES, P.C.

Patient Name:_____ **DOB:**_____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as quality assessments or evaluations, and physician certifications.

I give permission for Allergic Disease Associates, PC / The Asthma Center to:

☐ Leave a message regarding appointments and test results at (phone number)_____

☐ Share my protected health information with a physician:

Physician: _____ Phone: _____

Address: _____

☐ Share my protected health information with:

1) Name: _____ Phone: _____ Relationship: _____

2) Name: _____ Phone: _____ Relationship: _____

I have been informed by Allergic Disease Associates, PC / The Asthma Center of its Notice of Privacy Practices, containing a complete description of the uses and disclosures of my protected health information (available in all offices as well as on www.asthmacenter.com). I have been given the right and opportunity to review such Notice of Privacy Practices prior to signing this consent. I understand that Allergic Disease Associates, PC / The Asthma Center has the right to change its Notice of Privacy Practices and that I may contact Allergic Disease Associates, PC / The Asthma Center or access its website at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Allergic Disease Associates, PC / The Asthma Center restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Allergic Disease Associates, PC / The Asthma Center is not required to agree to my requested restrictions, but if Allergic Disease Associates, PC / The Asthma Center does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Allergic Disease Associates, PC / The Asthma Center has taken action relying on this consent.

I acknowledge that it is my responsibility to inform the practice of any changes in the above information.

I acknowledge that I have received the Notice of Privacy Practices.

Patient Signature	Date	Witness Signature	Date

New Patient Allergy History & Review of Symptoms

Patient Name: _____ Date of Birth: _____

What is the major reason for this allergy consultation? Check all that apply

☐ Allergies	☐ Coughing	☐ Medication Allergy
☐ Sinus Issues/Nasal Polyps	☐ Nasal Congestion	☐ Food Allergy
☐ Asthma/COPD	☐ Post Nasal Drip (PND)	☐ Eczema/Rash/Hives
☐ Shortness of Breath	☐ Sneezing	☐ Smell Loss
☐ Wheezing	☐ Runny Nose	☐ Other _____

When did your symptoms begin?_____

Symptom Frequency: ☐ Less than twice/wk ☐ 3 or more days/wk ☐ Every day ☐ More than 2 nights/wk

When are you symptomatic? WINTER SPRING SUMMER FALL YEAR-ROUND

Have you ever tried any medications for your symptoms? ☐ Yes ☐ No If yes, which?_____

Medical History

Have you ever had any of the following vaccines:

☐ Tdap (Tetanus, Diptheria, Acellular Pertussis)	Mo/Yr:_____	☐ Shingrix (Shingles)	Mo/Yr:_____
☐ Flu Vaccine	Mo/Yr:_____	☐ Last COVID Vaccine	Mo/Yr:_____
☐ Pneumovax 23	Mo/Yr:_____	☐ Other Vaccines, please list below:	
☐ Prevnar 13	Mo/Yr: _____	_____	Mo/Yr:_____
☐ Prevnar 20	Mo/Yr: _____	_____	Mo/Yr:_____
☐ RSV Vaccine	Mo/Yr: _____		

Have you been seen by:

Allergist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Cardiologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Dermatologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Endocrinologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
ENT	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Gastroenterologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Neurologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Pulmonologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Rheumatologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____

We would like any recent chest and sinus x-rays/CT scans and laboratory studies. Please bring a copy of the report with you or have it faxed to our office prior to your appointment.

Medication List:

Drug Name	*Milligrams (mg)*	*Frequency*

List any diagnosed medical conditions with dates of onset, and dates of surgical procedures, if any:

Environmental History:

WHAT TYPE OF HOME DO YOU HAVE? □ SINGLE FAMILY HOME □ ROWHOME/TOWNHOUSE □ TWIN/DUPLEX □ APARTMENT □ DORMITORY □ OTHER _____

LOCATION OF YOUR HOME: □ URBAN □ SUBURBAN □ RURAL AGE OF HOME: _____

NUMBER OF YEARS LIVING HOME: _____

DO YOU HAVE A BASEMENT, CRAWL SPACE, OR SLAB? □ NO □ YES

IF YES, IS IT: □ WET □ DRY □ DAMP □ MUSTY □ MOLDY IF MOLDY, WHERE IS IT VISIBLE? _____

DOES IT HAVE: □ CARPET □ DEHUMIDIFIER

WHAT TYPE OF HEATING DOES YOUR HOME HAVE? □ RADIATOR □ BASEBOARD □ FORCED AIR □ GAS □ OIL □ ELECTRIC □ COAL □ KEROSENE □ WOOD □ FIREPLACE

IS YOUR DRYER VENTED TO THE OUTSIDE? □ NO □ YES WHERE IS YOUR DRYER LOCATED? _____

DO YOU HAVE ANY HUMIDIFIERS? □ NO □ YES IF YES, WHERE? □ CENTRAL □ ROOM

DO YOU HAVE GAS APPLIANCES IN YOUR HOME? □ NO □ YES

IF YES, COULD YOU SMELL A GAS LEAK ODOR, IF PRESENT? □ NO □ YES

DO YOU HAVE A METHANE/CARBON DIOXIDE DETECTOR? □ NO □ YES

DO YOU HAVE AIR CONDITIONING IN YOUR HOME? □ NO □ YES IF YES, WHAT TYPE? □ CENTRAL □ ROOM

DOES AIR CONDITIONING IMPROVE YOUR SYMPTOMS? □ NO □ YES

DO YOU HAVE ANY AIR CLEANERS IN YOUR HOME? □ NO □ YES IF YES, WHAT TYPE? □ CENTRAL □ ROOM

IF ROOM AIR CLEANERS, IN WHICH ROOM(S)? _____

WHAT MATERIAL ARE YOUR PILLOWS MADE OF? □ FEATHER/DOWN □ SYNTHETIC □ FOAM

WHAT MATERIAL IS YOUR MATTRESS MADE OF? □ FEATHER/DOWN □ SPRING □ FOAM □ AIR MATTRESS □ OTHER_____

WHAT ARE YOUR BLANKETS MADE OF? □ FEATHER/DOWN □ SYNTHETIC □ COTTON □ WOOL

DO YOU HAVE CARPETING IN THE BEDROOM? □ NO □ YES IF YES, WHAT TYPE? □ AREA □ WALL TO WALL

IN YOUR BEDROOM, ARE THERE:

CURTAINS/DRAPES? □ NO □ YES

BLINDS/SHADES? □ NO □ YES

STUFFED ANIMALS? □ NO □ YES

PETS: □ NO CAT(S) # _____ #YRS. _____ ANY REACTIONS? _____

DOG(S) # _____ #YRS. _____ ANY REACTIONS? _____

OTHER(S) # _____ #YRS. _____ ANY REACTIONS? _____

IS THE PET EVER IN YOUR BEDROOM? □ NO □ YES DID YOU GROW UP WITH PETS? □ NO □ YES

ANY OTHER CURRENT PET EXPOSURE? □ NO □ YES IF YES, WHAT TYPE(S)? _____

IF EXPOSED TO OTHER PETS, HOW OFTEN AND WHERE? _____

HAVE YOU HAD EXPOSURE TO COCKROACHES/RODENTS/BEDBUGS? □ NO □ YES

IF YES, WHERE? □ WORK □ SCHOOL □ OTHER _____ WHEN? _____

DO YOU HAVE PLANTS IN YOUR HOME? □ NO □ YES IF YES, HOW MANY? <5 5-10 >10

ARE THERE ANY PLANTS IN YOUR BEDROOM? □ NO □ YES

WHICH ROOM(S) IN YOUR HOUSE CAUSE THE WORST SYMPTOMS? _____

DOES YOUR VACUUM CLEANER HAVE SPECIAL FILTERS? □ NO □ YES □ NOT SURE WHO VACUUMS AT HOME? _____

DO YOU USE ANY OF THESE ITEMS? □ COLOGNE/PERFUME □ SCENTED SOAPS/DEODORANTS

DO YOU REACT TO AEROSOL SPRAYS? □ NO □ YES IF YES, WHAT TYPE OF REACTION? _____

ARE YOU EXPOSED TO ANY RENOVATIONS? □ NO □ YES IF YES, WHERE? □ HOME □ WORK □ SCHOOL

ARE YOUR SYMPTOMS WORSE AT SCHOOL OR A WORKPLACE ENVIRONMENT? □ NO □ YES

HAVE YOU BEEN EXPOSED TO ANY POLLUTANTS/TOXINS/GASES/PASSIVE SMOKE/PAINTS/CHEMICALS? □ NO □ YES

Miscellaneous History:

HAVE YOU HAD ANY REACTIONS TO INSECT STINGS/BITES? □ NEVER STUNG/BITTEN □NO □ YES

IF YES, WHICH? □ BEE □ YELLOW JACKET □ WASP □ MOSQUITO □ FLY □ TICK □ OTHER _____

HAVE YOU HAD ANY REACTIONS TO LATEX? □ NO □ YES IF YES, WHAT TYPE OF REACTION? _____

HAVE YOU HAD ANY REACTIONS TO LOCAL/GENERAL ANESTHESIA? □NO EXPOSURE □ NO □ YES

HAVE YOU HAD ANY REACTIONS TO CONTRAST DYE FROM RADIOLOGY PROCEDURES (CAT SCAN WITH CONTRAST)?

□ NO EXPOSURE □ NO □ YES

Allergy Skin Testing:
Instructions, Information, and Informed Consent

The Asthma Center
ALLERGIC DISEASE ASSOCIATES, P.C.

Patient Name:_____ **DOB:**_____

DO NOT TAKE PRESCRIPTION OR OVER THE COUNTER ANTIHISTAMINES FOR 3 DAYS PRIOR TO YOUR SCHEDULED SKIN TESTING APPOINTMENT. If you have any questions regarding whether or not you are using an antihistamine, please contact our office.
You may continue all lung inhaler medications.

We request you do not bring small children with you when you are scheduled for skin testing, unless accompanied by another adult. At the beginning of your appointment, please inform the physician and/or nurse, prior to skin testing, if you are taking any beta-blockers or tricyclic anti-depressants, if you are pregnant, if you have a fever or if you are having difficulty breathing.

Allergy skin tests are methods of testing for allergy antibodies by introducing small amounts of the suspected allergens into the skin and noting whether positive reactions occur. Positive reactions consist of hive-like swellings and/or redness in the area surrounding the injection site. The results are read 10-20 minutes after the application of the allergens.

Several skin test methods are employed by our practice:

1) Prick method: In this method, the skin is pricked with a needle where drops of allergen had been previously placed. This is typically done on the back or, sometimes, on the forearm.
2) Intradermal method: This method consists of injecting small amounts of allergens into the superficial layers of the skin. This is typically performed on the upper arms and is done if the prick testing for the aero-allergen is negative.
3) Multi-test method: Allergen solutions are placed on the individual prongs of a multi-pronged plastic device that is pressed firmly on the back for < 5 seconds and then removed. This is typically done on the back and is reserved for young children.

Please notify the physician or clinical staff if you have a history of fainting during blood draws, receiving injections or any other procedure.

Interpretation of the clinical significance of skin test results requires careful review of the test results as well as a thorough review of the patient's history. Correlation of the skin test results and the patient's clinical history is essential in establishing which allergies are of clinical significance. After skin testing, your results will be reviewed by one of The Asthma Center physicians who will make recommendations regarding your treatment.

When you or your child come to our office for skin testing, you may be tested for allergic sensitivity to important selected aeroallergens and foods. In the metropolitan Philadelphia, Central and South Jersey areas, these may include trees, grasses, weeds, molds, dust mites, animal danders, and food allergens. The skin testing session usually takes 40 minutes. We recommend our patients wear a short-sleeve shirt on the day of the appointment in case intradermal testing is performed. Prick testing for adults and older children will be performed on the back followed by intradermal testing on the arms. The tests will be read within 10-20 minutes of application. Positive skin tests will gradually disappear over 30 minutes and, typically, no treatment is necessary.
Occasionally, local swelling at test sites will begin 4-8 hours after the skin tests were applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next several days. The use of topical steroids for these reactions may be helpful. Sometimes large local reactions will occur and last longer than a few days. Call The Asthma Center physicians if you have any questions regarding you or your child's reactions to skin testing.

Rarely, reactions may occur with skin testing that require immediate medical attention. These reactions may consist of any or all of the following symptoms:

- Itchy eyes, nose or throat
- Nasal Congestion or runny nose
- Tightness in the throat or chest
- Wheezing
- Shortness of breath
- Nausea or vomiting
- Hives and generalized itching
- Feeling faint or light-headedness
- Shock – only under extreme circumstances

Please note that these reactions rarely occur, and if any such reaction would occur, our staff is fully trained and available to treat these reactions.

Informed Consent

I have read the patient information sheet on allergy skin testing and understand that the opportunity has been provided to me to ask questions regarding the potential side effects of allergy skin testing. These questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me or my child against such reactions. All of my questions have been answered.

_____ _____ _____ _____
Patient's Signature Date Witness Signature Date

Note: For all patients who have received this information sheet and informed consent prior to your skin testing, please bring this form with you to your appointment. You may sign it before or during your visit.

If you are 12 years of age or older, and have any chest/lung symptoms like shortness of breath, wheezing, coughing, chest tightness or chest congestion, please complete this assessment form.

Asthma Control Test™:

PATIENTS: 1. Write the number of each answer in the score box provided.
2. Add up the score boxes to get the TOTAL.

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?

All of the time	Most of the time	Some of the time	A little of the time	None of the time	SCORE
(1)	(2)	(3)	(4)	(5)	

2. During the past 4 weeks, how often have you had shortness of breath?

More than once a day	Once a day	3 to 6 times a week	Once or twice a week	Not at all	
(1)	(2)	(3)	(4)	(5)	

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week	2 or 3 nights a week	Once a week	Once or twice	Not at all	
(1)	(2)	(3)	(4)	(5)	

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all	
(1)	(2)	(3)	(4)	(5)	

5. How would you rate your asthma control during the past 4 weeks?

Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completely controlled	
(1)	(2)	(3)	(4)	(5)	

TOTAL

RCAT (Rhinitis Control Assessment Test)

For Ages 12 and Up

Patients:
If you have any nasal symptoms, please complete the assessment test.

A. ***Write the number of each answer in the score box provided.***
B. ***Add up the score boxes and write in the total.***

1. <u>During the past week</u>, how often did you have nasal congestion? **SCORE**

Never	Rarely	Sometimes	Often	Extremely Often
5	4	3	2	1

2. <u>During the past week</u>, how often did you sneeze?

Never	Rarely	Sometimes	Often	Extremely Often
5	4	3	2	1

3. <u>During the past week</u>, how often did you have watery eyes?

Never	Rarely	Sometimes	Often	Extremely Often
5	4	3	2	1

4. <u>During the past week</u>, to what extent did your nasal or other allergy symptoms interfere with your sleep?

Not at all	A little	Somewhat	A lot	All the time
5	4	3	2	1

5. <u>During the past week</u>, how often did you avoid any activities (for example, visiting a house with a dog or cat, gardening) because of your nasal or other allergy symptoms?

Never	Rarely	Sometimes	Often	Extremely Often
5	4	3	2	1

6. <u>During the past week</u>, how well were your nasal or other allergy symptoms controlled?

Completely	Very	Somewhat	A little	Not at all
5	4	3	2	1

TOTAL

Patient's Name: _____ Today's Date: _____

Childhood Asthma Control Test for children 4 to 11 years old.

How to take the Childhood Asthma Control Test

- **Step 1** Let your child respond to **the first four questions (1 to 4)**. If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining **three questions (5 to 7)** on your own and without letting your child's response influence your answers. There are no right or wrong answers.
- **Step 2** Write the number of each answer in the score box provided.
- **Step 3** Add up the score boxes for the TOTAL.
- **Step 4** Take the test to the doctor to talk about your child's total score.

Have your child complete these questions.

1. How is your asthma today?



0	1	2	3	SCORE
Very bad	Bad	Good	Very good	

2. How much of a problem is your asthma when you run, exercise or play sports?



0	1	2	3	
It's a big problem, I can't do what I want to do.	It's a problem and I don't like it.	It's a little problem but it's okay.	It's not a problem.	

3. Do you cough because of your asthma?



0	1	2	3	
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.	

4. Do you wake up during the night because of your asthma?



0	1	2	3	
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.	

Please complete the following questions on your own.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5	4	3	2	1	0	
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday	

TOTAL

New Patient Referral Intake Survey

1. Name : (First) _____ (Last) _____

2. How Did You Hear About Us? (Check all that apply)

☐ Facebook
☐ Family
☐ Friend
☐ Insurance Company Website / Customer Service
☐ Newspaper
☐ Online Search
☐ Physician
☐ Pollen Counts
☐ Radio
☐ Review Website (Google, Yelp, Healthgrades, RateMDs, etc)
☐ Television
☐ Other (please specify)_____

3. What Made You Choose Us? (Check all that apply)
☐ Advertising
☐ Available Appointment
☐ Insurance Accepted
☐ Location
☐ Online Reviews
☐ Personal Recommendation
☐ Physician's Credentials
☐ Size of Group
☐ Other (please specify)_____

4. What is your age? (Patient or Parent/Guardian of Patient)
☐ 18 to 24
☐ 25 to 34
☐ 35 to 44
☐ 45 to 54
☐ 55 to 64
☐ 65 to 74
☐ 75 or older

5. What is your gender? (Patient or Parent/Guardian of Patient)
☐ _____
☐ Prefer not to say

6. Zip Code_____

7. Email Address_____

By providing my email address I am signing up to receive emails from The Asthma Center. Emails include office announcements & emergency closures, allergy shot hours, pollen counts, allergy & asthma news and health tips, and other marketing communications. Subscriptions can be managed online and unsubscribed at any time. No medical information and no protected health information (PHI) will be exchanged through this service.

Parent / Legal Guardian Consent for Evaluation & Treatment of Minor Child

If a parent or legal guardian will not be accompanying a minor (less than 18 years old), the parent or legal guardian must complete this form.

Patient Name: _____ Office: _____

Patient Date of Birth: _____

I, (name of parent or legal guardian) _____
hereby give permission and consent for my

minor child, (name) _____ to be evaluated and treated at The Asthma Center in my absence. The evaluation and treatment may include, but is not limited to:

- to be examined and treated during a medical office visit by The Asthma Center Provider(s)
- to undergo allergy skin testing
- to receive allergy / venom / biologic / vaccine injection(s)
- to undergo a scheduled procedure (i.e rhinoscopy, patch testing, etc.)
- to undergo a Methacholine Challenge or a Complete Pulmonary Function Test

I will provide my child with my emergency contact number prior to each visit at The Asthma Center. I am aware that there may be potential side effects, and/or adverse reactions for the evaluation and/or treatment.

In my absence, the following person(s) will be accompanying my child to The Asthma Center: _____,

(relationship to child) _____ .

I also give my permission to the person(s) accompanying my child to have access to my child's personal health information on the day of the visit to The Asthma Center.

In the event of a reaction to any injection(s), procedure(s) and/or testing, I give my consent to the provider(s) and the staff at The Asthma Center to provide my child with the necessary medical treatment(s). I understand, if necessary, that this treatment may include a 911 call and treatment at the local hospital emergency department.

_____ _____
Parent or Guardian Signature Date

_____
Emergency Contact Telephone Number

_____ _____
Witness Signature Date

ALLERGIC DISEASE ASSOCIATES, PC, T/A THE ASTHMA CENTER

FINANCIAL POLICY

Welcome to The Asthma Center. We are committed to providing you with the best care possible. To support the achievement of this goal it is best if everyone is aware of our financial policy, which is an agreement between our practice, The Asthma Center, and the patient and/or guarantor. Your clear understanding of the financial policy agreement is important to our professional relationship.

The following is intended to clarify our financial rules and payment practices for the benefit of our patients. This financial policy is a legal arrangement between the Practice and its patients. By signing below, you, as our patient (the patient's legal representative, as applicable) agree to abide by its terms and requirements.

Please also note that information in this Policy is not intended to be interpreted as legal advice or as interpretation of the term of patient's insurance policy or benefit plan. Patients must refer any questions regarding medical services coverage, amount of coverage, co-payments, deductibles, out of pocket costs, mandates, claim adjudication, appeal, etc. to their carrier or legal counsel.

INSURANCE

At each visit, please bring identification (e.g., current driver's license or government issued ID) and a copy of your insurance card. Payment for services is due at the time services are rendered, except as outlined below. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered.

It is the responsibility of the patient to provide accurate and current insurance information. Inaccurate or untimely information given to our staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment. If the patient is a dependent, you are responsible for all charges even if you did not accompany the patient to our office for treatment.

NON-EMERGENCY APPOINTMENTS

Routine follow-up, allergy injections and the like may be rescheduled or cancelled if there are outstanding balances or if a co- payment is not made at time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer (if you are insured by a group benefit plan), and your insurance company. ***It is important for you to be an informed consumer who understands the specifics of your insurance policy.***

BILLING

Patients are required to have a valid credit card on file with us. Please refer to our Credit Card Authorization Form on the last page of this policy. Patients that do not have a valid credit card on file will not be seen.

We will provide you with an itemized statement, monthly, as well as when requested. We accept cash, checks, MasterCard, Visa, Discover, American Express and offer online payments through our payment processor. **Patient-responsibility balances are due within 30 days of the statement date, unless prior arrangements have been made with the billing department**. A $20 billing fee will be charged to you if your co-payment is not made at the time of service. A $50 fee will be charged for all returned checks and your account will be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared. Any patient balances that have not been paid within 30 days of the last billing will incur a late fee of $50.00. Individuals with balances not paid in full within 90 days of the initial statement date will receive a final written notice that will inform you that your balance will be forwarded to a collection agency. An additional collection fee of $50 will be charged on all collection accounts. Please note these fees are not covered by your insurance company. If your account is forwarded to a collection agency, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care. We will attempt to collect any unpaid balance to the extent we are allowed by law, regardless of whether you are still a patient. Also, please note that you are responsible for all charges incurred for dependent patients even if you are not the

guarantor or other responsible person for such charges under the applicable insurance policy or otherwise. Additionally, if the patient is a dependent, you are financially responsible for all charges even if you did not accompany the patient to our office for treatment.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department (215-569-1111, option 2) promptly for payment arrangements and assistance in the management of your account

Should your account balance become uncollectible due to bankruptcy, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care.

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY (In-network insurance)

You are responsible for paying all co-payments at the time of service and are subject to a $20 billing fee if not paid at time of service. Annual deductibles, coinsurances, and any unpaid balance owed to us will be billed to you in accordance with the explanation of benefits (EOB) from your insurance. As a courtesy to you, all services performed in our office will be submitted to your insurance on your behalf.

All in-network insurance carriers have a fee schedule (allowable charge amount) according to which they will reimburse The Asthma Center. However, the practice's allowable charge amount may be higher than what the insurance company reimburses, or it may not be a covered service. Therefore, any balances not paid by your insurance become the responsibility of the patient/guarantor consistent with your Explanation of Benefits (EOB).

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY (Out of network insurance)

If we do not participate with your insurance plan, we are not able to bill your insurance and we cannot accept payment from them for our services. If we do not participate with your insurance, we can still provide you with medical care, however you will be responsible for full payment of services at the time of your visit(s). Patients will be responsible for contacting their insurance to ensure they have out of network benefits and to understand what their out of network benefits cover and the out-of-pocket costs. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement of your out-of- pocket cost. Not all services provided by The Asthma Center are covered benefits in all contracts. Patients are financially responsible for all services which may be more than the allowable amount of your insurance plan. Payment for services is due at the time of service. A $20 billing fee will be added to balances not paid at the time of service.

MEDICARE

Patients are responsible for the annual deductible and/or 20% of the Medicare allowable amount for all covered services. (Medicare supplemental insurance may cover this amount.)

NON-COVERED SERVICES AND SELF PAY

If our services are not covered by your insurance plan or if you have no insurance, you agree you are financially responsible for all charges. If the patient is a dependent, you are financially responsible for all charges even if you did not accompany the patient to our office for evaluation and/or treatment.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Missed appointments represent a cost and inconvenience to us and to other patients who could have been seen in the time set aside for you. For cancellations, 48 hours notice prior to the appointment time is required. For new patients, failure to provide 48 hours notice of cancellation or failure to come to your appointment will result in a $150.00 fee.

For follow-up appointments, failure to provide 48 hours notice of cancellation or failure to come to your appointment will result in a $75.00 fee. For special testing (including allergy testing, food or drug challenges, methacholine or exercise challenges, and desensitization), a missed appointment or cancellation with less than 72 hours notice may result in a fee of $250-$450 based on the scheduled service (as indicated on the testing information sheet which you

received when scheduling the test). Notice of cancellation must be provided by direct phone contact (speaking with a member of our staff during business hours). Notice will NOT be accepted by any other means (such as voicemail, email, fax, or text messaging). **Your credit card on file will be charged accordingly for missed appointments.** Please note these fees are not covered by your insurance company.

We reserve the right to discharge patients who miss multiple appointments, fail to give 48-72 hours prior notice of cancellation, repeatedly cancel appointments or repeatedly do not show up for scheduled appointments.

FORMS AND FEES

There is a $20-$30 fee for the review and completion of all forms. The fee depends on the type of form to be completed. (i.e. school/camp forms, disability, FMLA, etc.) There is a charge for copies and release of medical records.

REFERRALS

If your insurance plan requires a referral for you to see a specialist, for office visits, procedures or allergy injections, you are responsible for obtaining and keeping track of all referrals. You will have to reschedule your appointment if you do not have a valid referral at time of services. If a patient chooses to be seen without a referral form at the time of service, the patient will be responsible for payment in full at the time of service. We will NOT accept any referrals for services after services are rendered.

FOR MEDICARE PATIENTS ONLY

MEDICARE ASSIGNMENT FOR MEDICARE PATIENTS - MEDICARE RELEASE

Under the Medicare Law, effective 9/1/90, it is our obligation to process Medicare claims for our patients. In order to comply with this law, it is necessary that we have you acknowledge and sign below the following statement:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Allergic Disease Associates, PC for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine

these benefits of the benefits payable for the related services."

Signature of Patient or Legally Authorized Representative):

Name: _____

Date: _____

Relationship to Patient: _____

THE FINANCIAL AGREEMENT

We must emphasize that as specialty providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you. When you become a patient in our practice, we will ask you to sign a copy of our financial policy. Please prepare for your first visit by signing our financial policy in advance. The Asthma Center team thanks you for choosing to receive your care at The Asthma Center. It is our pleasure to care for you.

ACKNOWLEDGEMENT OF RECEIPT

ALLERGIC DISEASE ASSOCIATES, PC, T/A THE ASTHMA CENTER

FINANCIAL POLICY AND AGREEMENT:

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY FROM ALLERGIC DISEASE ASSOCIATES, PC, T/A THE ASTHMA CENTER. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION, OUR PRACTICE COLLECTION FEE, ANY LEGAL COSTS OR COURT COSTS, IN ADDITION TO THE ORIGINAL AMOUNT DUE, AS THE LAW ALLOWS.

IN ADDITION, I UNDERSTAND AND AGREE TO RECEIVING INFORMATION FROM THE PRACTICE VIA EMAIL. BY THIS AUTHORIZATION I ACKNOWLEDGE THAT THERE MAY BE INHERENT RISKS ASSOCIATED WITH ELECTRONIC COMMUNICATIONS, INCLUDING POTENTIAL DELAYS, DATA LOSS, UNAUTHORIZED ACCESS, AND SECURITY BREACHES. FURTHERMORE, I ACKNOWLEDGE AND AGREE THAT IT IS MY RESPONSIBILITY TO SECURE MY ELECTRONIC COMMUNICATION SYSTEMS TO ENSURE THE SECURITY OF SENSITIVE INFORMATION SENT TO ME. I HEREBY WAIVE ANY CLAIMS AGAINST ALLERGIC DISEASE ASSOCIATES, PC T/A THE ASTHMA CENTER (THE “PRACTICE”) FOR DAMAGES ARISING FROM THOSE RISKS ASSOCIATED WITH ELECTRONIC COMMUNICATION SYSTEMS AND AGREE TO USE THE SERVICE AT MY OWN RISK.

I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO ME AS THE PATIENT/GUARANTOR.

Name of Patient _Please Print: _____Date: _____

Signature of Patient (or Legally Authorized Representative*): _____

Date: _____

***RELATIONSHIP TO PATIENT:** _____

PLEASE PROVIDE GUARDIANSHIP OR CUSTODY OR LEGAL APPOINTMENT DOCUMENTATION

Credit Card Authorization Form
The Asthma Center / Allergic Disease Associates, PC (the "Practice")

To all our Patients:

Pursuant to our Financial Policy agreement, it is our policy to require patients to keep a current debit/credit card securely on file with our payment processor. We will submit a bill for every office visit and await payment from the insurance carrier whose information you have given to us. Your insurance carrier provides you with an Explanation of Benefits (EOB) statement which explains how your insurance coverage is applied and how much, if any, it paid to us. In accordance with this adjudication, any or all charges not covered are determined to be the patient's responsibility. Therefore, your credit card will be used to secure the unpaid amount or balance. Please note, in the event you wish to dispute the carrier's benefit payments, you must follow the claim appeal or review process required by the terms of your plan or policy. If you prevail in the appeal or review process, we will credit or reimburse you for any additional payments we might receive from your insurance carrier.

I understand, acknowledge and agree to the following terms:

- I am responsible for payment of all charges for services I receive from the Practice. I acknowledge and agree that co-pays, co-insurance, and any deductibles mandated by the terms of any insurance policy I own, or by my relationship with any other party/payor I may be affiliated with, are my obligation and are due at the time of service. The Practice may deny services for my failure to pay a co-pay or any outstanding balance at the time of service. Charges that do not successfully process with my insurance carrier or are denied by my credit card company or bank, will remain my financial responsibility. ***Any charge I have not paid within 30 days from the last visit, will incur a late charge of $50.00***

- I authorize the Practice and/or its designated payment agent(s) to apply charges to my payment card for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) co-payments, (iii) co-insurance, (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
- **I will not be provided with advance notice of payments authorized by this signed Credit Card Authorization Form.** Transaction receipts will be maintained in the patient file or will be emailed to me at the email address provided below. I authorize the above practice and/or its designated provider(s) to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement. I understand and agree that authorization for payment of services already rendered cannot be cancelled or refunded. I agree to notify the Practice in writing of any changes in my payment or other information. **I authorize the Practice to charge my credit card for all charges incurred for dependent patients even if I am not the guarantor or other responsible person for such charges under the applicable insurance policy or otherwise, and even if I did not accompany the patient to our office for treatment.**

I, the undersigned, authorize and request that the Practice charge my credit card for any outstanding balances when due. This authorization relates to all charges not covered by my insurance company for services provided to me by the Practice. My card and payment information will remain securely stored for future use by a third-party secure credit card processor that administers the billing and collection process of the Practice. In addition, I understand and agree to receiving information from the Practice via email. By this Authorization I acknowledge that there may be inherent risks associated with electronic communications, including potential delays, data loss, unauthorized access, and security breaches. Furthermore, I acknowledge and agree that it is my responsibility to secure my electronic communication systems to ensure the security of sensitive information sent to me.
I hereby waive any claims against Allergic Disease Associates, PC T/A The Asthma Center (the "Practice") for damages arising from those risks associated with electronic communication systems and agree to use the service at my own risk.

This Authorization will remain in effect until revoked by me in writing.
I declare under penalty of perjury under the laws of the United States of America that my identity, signature and the foregoing is true and correct.

_____

Cardholder Name as it Appears on Card | Cardholder Email Address

_____

Cardholder Billing Address | City | State | Zip Code

_____

Phone Number | MRN

_____

CARDHOLDER SIGNATURE | Date