LATE POLICY

We request that you arrive in the clinic **at least 15 minutes** prior to your scheduled time to fill out or clarify insurance papers and referrals. This will allow our nursing staff to get you comfortable into an examination room by the time of your scheduled appointment.

If you arriver later than your scheduled appointment, you will be rescheduled if the provider's schedule allows. If there is no time available for the duration of your provider's scheduled session, the clinical team will work with you to provide the best alternative, or to reschedule for another day.

NEW LOCATION

JUNE 2021

Rock Pointe III

1330 N. Washington, Suite 4200
Spokane, WA 99201

FREE PARKING

Spokane Allergy & Asthma Clinic

OUR MISSION STATEMENT

The Spokane Allergy & Asthma Clinic is committed to providing the highest quality individualized care possible, utilizing the most current knowledge and technology, provided by our team of skilled professionals.

Tel: 509-747-1624

SpokaneAllergy.com

WHAT DOES "BOARD CERTIFIED" MEAN?

To be board certified as an allergist, a physician must first be certified by the American Board of Internal Medicine or the American Board of Pediatrics. They must then complete an intensive two-year accredited training program and pass a comprehensive written exam by the American Board of Allergy, Asthma & Immunology. The allergist/immunologist, with his or her specialized training and expertise, can develop a treatment plan for each individual condition.

ALLERGISTS/IMMUNOLOGISTS TREAT PATIENTS WITH THE FOLLOWING PROBLEMS AND/OR CONDUCT RESEARCH ON:

- Diseases of the respiratory tract, such as allergic rhinitis, sinusitis, asthma and hypersensitivity pneumonitis
- Skin disorders, including atopic dermatitis (eczema), contact dermatitis or urticaria (hives)
- Gastrointestinal disorders caused by immune responses to foods
- Adverse reactions to drugs, other pharmacologic agents and diagnostic testing materials
- Insect sting reactions
- Symptoms of disorders caused by immunodeficiency.

IMPORTANT INFORMATION

INSURANCE BILLING

We bill most insurance companies. However, your specific plan may not cover your visit at our clinic. We recommend that you contact your insurance carrier prior to your visit to determine your insurance coverage. YOU WILL NEED TO BRING YOUR INSURANCE CARD AND ALL OTHER REQUESTED INFORMATION AT THE TIME OF YOUR VISIT. Treatment cannot be provided without it. INSURANCE COMPANIES REQUIRE THE CARD HOLDER'S DATE OF BIRTH FOR BILLING PURPOSES AND CLAIMS WILL BE DENIED WITHOUT THE CORRECT INFORMATION. Please present the correct information at your appointment.

DSHS OF WASHINGTON

You will need to bring your current card at the time of your visit. Treatment cannot be provided without your insurance card.

REFERRALS

Many insurance companies, including managed care, require a written referral or authorization number for patients to see a specialist. YOU ARE RESPONSIBLE FOR GETTING THE REFERRAL FROM YOUR PRIMARY CARE DOCTOR. You will be responsible for the cost of any visits that are not properly referred.

MINORS

Parents MUST accompany children under the age of 18 to ALL visits.

IMPORTANT INFORMATION

PRIOR TO YOUR FIRST VISIT

For **new** exams, please do not take **ANTIHISTAMINE**-containing medications for **3-5 days** prior to your visit as they block skin test reactions. **Antihistamines** can include but are not limited to:

- Allegra™
- Clarinex™
- Benadryl™
- Loratadine
- Chlorpheniramine.
- Zyrtec™
- Claritin™
- Xyzal™
- Diphenhydramine

DO NOT stop any of your other medications. If you are unable to stop antihistamine-containing medications, please do not cancel your visit. Please have your questionnaire and patient information sheet **completed** before your appointment. If you have any questions, please call the office prior to your visit.

SKIN TESTING

A puncture **skin test** device may be used to perform **multiple skin** tests. This **testing** may cause some discomfort but is **not painful**, and generally there is no bleeding.

PAYMENTS

If your insurance requires a co-payment, the co-payment will need to be collected at the time of your visit. If you have a deductible or no insurance, payment is expected at the time of your visit. We gladly accept VISA, Master Card and Discover.

SPOKANE ALLERGY and ASTHMA CLINIC

Please PRINT clearly: Today's date: ___/___/____

Patient Information: ___ New patient ___ Name change ___ Address change ___ Insurance change

Patient Name: ____

SSN#: _____/_____/_____ Date of Birth: _____/_____/_____ Age: _____ Sex: ___ male ___ female

Home Address: ______________________ City__________________ State___ Zip_______

Mailing Address: if different: ____

Phone: Which number do you prefer we call first? ___ Home ___ work ___ cell ___ message

Home: (____) _____-_____ Work: (____) _____-_____ Cell: (____) _____-_____ Mess: (____) _____-_____

E-mail: ____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: ______________________________ Social Security #__________________

Date of Birth: _____/_____/_____

Address: ______________________ City__________________ State___ Zip_______

Home Phone: (____) _____-_____ Work phone: (____) _____-_____ Cell: (____) _____-_____

Relationship to Patient: ______________________________

PAYMENT POLICY

The Adult or Guardian, who brings in the patient if a child, will be responsible for **all** copayments and deductibles. Spokane Allergy and Asthma Clinic will **not** forward bills to other parties, regardless of court rulings or divorce decrees.

PRIMARY INSURANCE COVERAGE:

Insurance Company Name: ______________________________ Policy Type: ___ HMO ___ PPO

Address of Claim Center: ______________________ City__________________ State___ Zip_______

Member ID #: ______________________________ Group Name or ID#: __________________

The following is **REQUIRED if the insured is not the subscriber of the insurance.

Name of Subscriber: ______________________ Subscriber's ID #: __________________

Subscriber Address ____

Subscriber's SSN#: _____/_____/_____ Subscriber's Date of Birth: _____/_____/_____

Relationship to insured: ___ Self ___ Mother ___ Father ___ Spouse ___ other

SECONDARY INSURANCE COVERAGE:

Insurance Company Name: ______________________________ Policy Type: ___ HMO ___ PPO

Address of Claim Center: ______________________ City__________________ State ___ Zip _______

Member ID #: ______________________________ Group Name of ID#: __________________

** The following is **REQUIRED** if the insured is not the subscriber of the insurance.

Name of Subscriber: ______________________ Subscriber's ID#: __________________

Subscriber's SSN#: _____/_____/_____ Subscriber's Date of Birth: _____/_____/_____

Relationship to insured: ___ Self ___ Mother ___ Father ___ Spouse ___ other

Signature: ______________________________ Date: ______________ **please continue ⇒**

Spokane Allergy & Asthma Clinic & Clinical Research

NOTICE OF PRIVACY PRACTICE – ACKNOWLEDGEMENT

Dear Patient,

Health care practitioners have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health-care providers and health plans.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a health care practitioner, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your practitioner, the hospital or other health –care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We also take precautions in our office to safeguard your health information such as training our employees and employing computer security measures.

This Notice of Privacy Practices attached to this letter explains our privacy practices. It contains very important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information. Please feel free to ask your practitioner about exercising your rights or how your health information is protected in our office.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices to read. If you would like a personal copy to take with you, you will be provided with one from the receptionist.

____ ____________________
Patient Signature/(if under 18) Legal Guardian Signature Date

____
Printed name if signed on behalf of the patient relationship to patient

Please list any individuals we can discuss your medical information or your child's medical information with (ie. appointments, test results, treatment recommendations)

____
Name relationship to patient

____
Name relationship to patient

May we leave personal information on your answering machine at home? ____ work? ___ cell? ___?

If yes, names of people we can give info to: ___________________________________

Steven Kernerman, DO Kerry Drain, MD Ronald England, MD
Rayna Doll, DO Mariya Giles, ARNP Tamara Zey, ARNP

Dear Patient and/or Parent/Guardian:

~~This form and your signature below serves as formal notification of our patient balance/billing policy.~~

We will bill your insurance company as a courtesy. If for any reason there is no response from your insurance company, you will get a bill from us and you will need to pursue this matter with your insurance company, and payment is expected to be paid to our office. The balances are usually for any unpaid medical services to you by our office, co-payments, co-insurance, information needed from the insured or member, non-met deductibles, non-covered services per your particular plan's benefits, pre-existing condition not payable by your particular insurance plan, or no show/late cancellation fees.

It is the policy of our office to send *only three statements.* The statements are sent at 25-day intervals. We will send you collection letters as well. If no payment is received on your account during the 75-day period, your account will be turned over to collections *without additional notice.* We feel that two months is a reasonable amount of time to make payments on your account.

For your convenience, accounts can be paid using your MasterCard or Visa. You can indicate your credit card information on the statement. You may also pay it over the phone using the credit cards listed.

FINANCIAL SERVICES:

We understand that there may be times when financial difficulties arise without warning. Under special circumstances, payment arrangements may be made. Accounts on a payment plan are required to make a payment each month. Missed payments could result in collections. Please contact our Billing Department at 509-747-1624, option 4, for any questions or to set up payment arrangements.

Your signature on this form acknowledges your understanding of this policy. Thank you for choosing Spokane Allergy and Asthma clinic for your medical care.

______________________________ ______________________________
Patient Name (please PRINT) If patient is a minor, parent/guardian NAME

Patient Date of Birth: ______-______-______ Date: ______-______-______

____
Patient/Parent/Guardian SIGNATURE

Rockpointe Plaza, 1330 N. Washington, Bldg. III, Suite 4200
Spokane, WA 99201
Phone: 509-747-1624 Fax: 509-747-6774

FINANCIAL POLICY..Please continue ⇒

Who may be contacted in the event of an emergency?

Name: ______________________________ Phone: ________________ Relationship: __________

May we leave personal information on your answering machine at home? ____ work? ___ cell? ___?
If yes, names of people we can give info to: ____

ASSIGNMENTS OF INSURANCE BENEFITS:
I assign all medical, surgical, immunology benefits to which I am entitled; private insurance and any other health plans to: ***SPOKANE ALLERGY AND ASTHMA CLINIC.*** This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that responsibility for payment of Medical Services in this office for myself or my dependants is mine, due and payable at the time services are rendered. I further understand that insurance is billed as a courtesy and I am responsible for any charges unpaid by the carrier.

I understand there is a *minimum* charge of $50.00 for **missed** appointments or appointments **not cancelled with at least 24 hours'** notice. **We Require 24-hour Notice to Cancel Appointments.**

Signature: ________________________________ ***Date:*** ____________________

**** Financial Policy for MEDICARE PATIENTS *****

Please check one: **I have paid my insurance deductible for the calendar year:**
_____ Yes _____ No _____ Don't Know

MEDICARE PATIENTS ONLY:
I request payment of authorized Medicare benefits be made either to me or on my behalf to **Spokane Allergy and Asthma Clinic** for any services furnished to me by the listed provider/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 or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

MEDICARE Patient's Name (Please Print): ____
MEDICARE Patient's Signature: ____
MEDICARE NO. ____________________________ DATE: ______________________
PROVIDER: ______________________________________

SPOKANE ALLERGY AND ASTHMA CLINIC ALLERGY QUESTIONNAIRE

Please complete this questionnaire to have it available before your first office visit. This information is part of your medical record and will be treated confidentially. If some questions are not appropriate to your situation, move to the next section.

Patient's Name: ______________________ Birthday: ____________ Consult requested by: ____________

Name of Person Filling Out This Form: ______________________________ Date of Visit: ____________

What is your primary purpose for this allergy evaluation? ______________________________

Who is your Primary physician: ______________________________

What is your preferred pharmacy? ______________________________

RESPIRATORY PROBLEMS

Please check YES ☒ for any current SYMPTOMS, or EXPOSURES THAT MAKE THESE SYMPTOMS WORSE. Leave these boxes blank if you do not feel that they have been a recurrent problem.

EYES	MOUTH, THROAT	EXPOSURES THAT MAKE THESE SYMPTOMS WORSE
☐ Itchy eyes	☐ Itchy throat	☐ Prolonged laughter
☐ Red eyes	☐ Sore throat	☐ House dusting
☐ Watery eyes	☐ Hoarse voice	☐ Wet or moldy areas
☐ Swollen, puffy eyes	☐ Frequent throat clearing	☐ Barns and hay
☐ Dry eyes	☐ Bad breath	☐ Springtime pollen
☐ Eye discharge		☐ Lawn mowing
☐ Eye drainage	**LUNGS**	☐ Cleaning solvents
☐ Other:	☐ Frequent daytime cough	☐ Irritating odors
	☐ Nighttime coughing	☐ Airborne chemicals
NOSE, EARS, SINUS	☐ Wheezing	☐ Wood smoke
☐ Post nasal drip	☐ Chest tightness	☐ Tobacco smoke
☐ Sneezing	☐ Chest pain	☐ Perfumes, air fresheners
☐ Nasal dripping and sniffling	☐ Shortness of breath	☐ Christmas trees
☐ Nasal congestion	☐ Exercise intolerance	☐ Latex rubber products
☐ Recurrent sinus infections	☐ Recurrent bronchitis	☐ Cats
☐ Sinus pain/ pressure	☐ Recurrent pneumonia	☐ Dogs
☐ Mouth breathing	☐ Other:	☐ Horses
☐ Nighttime snoring		☐ Cattle
☐ Nasal itching	**EXPOSURES THAT MAKE THESE SYMPTOMS WORSE**	☐ Goats
☐ Increased frequency of colds	☐ The spring months (March-June)	☐ Gerbils
☐ Nosebleeds	☐ The summer months (June-Aug)	☐ Guinea pigs
☐ Reduced ability to smell	☐ The autumn months (Sept-Nov)	☐ Hamsters
☐ Nasal polyps	☐ The winter months (Dec-Feb)	☐ Pet mice or rats
☐ Itchy ears	☐ Crying or yelling	☐ Rabbits
☐ Dizziness	☐ Very cold air	☐ Pet birds or feathers
☐ Ear "popping" or pressure	☐ Very hot and humid air	☐ Other:
☐ Recurrent ear infections-otitis media	☐ Windy days, dust storms	
☐ Middle ear fluid (effusions)	☐ Rainy days, wet weather	
☐ Diminished hearing	☐ Acquired viral URI's or "colds"	
☐ Other:	☐ Heartburn or acid reflux	
☐	☐ Exercise or running	

At what age did you first begin having these SYMPTOMS? ____________

Have you ever had any Allergy Skin testing or blood testing for these problems? ____________

Have you ever been treated with Allergy shots? ____________

Names of any previous Allergy, ENT, or Respiratory specialists that you have seen: ____________

SKIN, GASTROINTESTINAL AND FOOD-RELATED PROBLEMS

Please check YES ☒ for any SYMPTOMS or EXPOSURES OR FOODS THAT MAKE THESE SYMPTOMS WORSE. Leave these boxes blank if you do not feel that they have been a recurrent problem.

SKIN	GASTROINTESTINAL	
☐ Dry skin	☐ Bloating	☐ Barley
☐ Scaly skin	☐ Recurrent nausea	☐ Corn or corn by-products
☐ Itchy skin	☐ Recurrent vomiting	☐ Rice
☐ Red and inflamed skin	☐ Recurrent heartburn	☐ Peanuts
☐ Eczema	☐ Regurgitation or reflux of food	☐ Soybeans
☐ Red, raised, itchy "hives	☐ Chest pains with swallowing	☐ Green beans, navy beans
☐ Deep tissue swellings	☐ Sticking of swallowed food	☐ Peas, lentils
☐ Recurrent blisters	☐ Recurrent abdominal pains	☐ Walnuts, pecans
☐ Contact allergic dermatitis	☐ Recurrent diarrhea	☐ Almonds, hazelnuts
☐ Recurrent skin infections	☐ Recurrent constipation	☐ Cashews, pistachios
☐ Hair loss	☐ Belching	☐ Brazil nuts
☐ Other:	☐ Flatulence	☐ Pine nuts
	☐ Loss of appetite	☐ Mustard
		☐ Sesame or poppy seeds
		☐ Flaxseed
EXPOSURES THAT MAKE SKIN SYMPTOMS WORSE	**SYMPTOMS RELATED TO EATING SPECIFIC FOODS**	☐ Sunflower seed
☐ Cold weather or contact with ice	☐ Mouth and throat itching	☐ Buckwheat
☐ Low humidity or dry weather	☐ Hives or rash only near the mouth	☐ Cod, salmon, halibut
☐ Contact with water or bathing	☐ Abdominal cramping/pain nausea	☐ Shrimp, crab, lobster
☐ Overheating	☐ Widespread hives or rash	☐ Clams, oysters
☐ Exercise or sweating	☐ Worsening eczema	☐ Beef, lamb, pork
☐ Scratching	☐ Other:	☐ Chicken, turkey
☐ Tight clothing, sustained pressure		☐ Apple, peach, cherry
☐ Sustained vibration	**FOODS THAT MAKE THESE SYMPTOMS WORSE**	☐ Berries
☐ Sunlight	☐ Artificial food dyes	☐ Bananas
☐ Cosmetics	☐ Wine, beer, alcoholic beverages	☐ Avocados
☐ Latex rubber (gloves)	Sulfites in foods	☐ Citrus fruits
☐ Poison ivy/poison oak	☐ Monosodium glutamate (MSG)	☐ Kiwi, mangoes, tropical fruits
☐ Contact with nickel in clothing	☐ Cow's milk, ice cream, cheese	☐ Carrots
☐ Metals in jewelry	☐ Goat's milk	☐ Celery
☐ Soaps, detergents	☐ Eggs	☐ Potatoes
☐ Perfumes	☐ Wheat	☐ Other:
☐ Creams or lotions	☐ Oats	☐ Other:
☐ Topical antibiotics (neomycin)	☐ Rye	
☐ Topical eye drops		

At what age did you first begin having these SYMPTOMS? ____________

Have you ever had Allergy "Patch testing" done to confirm these sensitivities? ____________

Names of anyprevious Dermatology or Gastroenterology (GI) specialists that you have seen: ____________

STINGING INSECT REACTIONS (involving mosquitoes, bees, wasps, hornets, yellow jackets, fire ants, etc.)

Please check YES ☒ for any SUSPECTED INSECTS, SYMPTOMS, and REQUIRED TREATMENTS that have occurred with past stinging insect reactions. Leave these boxes blank if there has not been a prior reaction to insect stings.

SUSPECTED INSECTS CAUSING THESE SYMPTOMS	SYMPTOMS OCCURRING AFTER YOUR STING	TREATMENTS REQUIRED FOR THESE SYMPTOMS
☐ I do not know the type of insect	☐ Large localized swelling at the site	☐ Urgent care or clinic sick visit
☐ Honey bee	☐ Widespread rash (hives)	☐ Emergency room visit
☐ Bumble bee	☐ Swelling distant from the sting site	☐ Hospitalization
☐ Wasp	☐ Throat tightness, hoarseness	☐ Epinephrine injection
☐ Hornet (yellow)	☐ Cough, chest tightness, wheeze	☐ Intravenous fluids
☐ Hornet (bald faced)	☐ Abdominal pains	☐ Oral or injected antihistamines
☐ Yellow jacket	☐ Nausea, vomiting, diarrhea	☐ Oral or injected steroids
☐ Fire ant	☐ Lightheadedness, altered vision	☐ Other:
☐ Mosquito	☐ Lowered blood pressure, shock	☐ Other:
☐ Other:	☐ Other:	☐ Other:

At what age did you first begin having these sting reactions? ____________

Have you ever had Allergy Skin testing or blood testing for this problem? ____________

Have you ever been treated with Allergy shots for this problem? ____________

Namesof any previous Allergy specialists that you have seen for this problem: ____________

PREVIOUS MEDICATION REACTIONS

List any medications that have caused an adverse reaction. Describe the type of reaction (i.e. rash, or abdominal pain). Also, note your approximate age when this reaction occurred. Leave the boxes blank if you have not had a prior medication reaction.

MEDICATION NAME	TYPE OF REACTION	APPROXIMATE AGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

ALLERGIC FAMILY HISTORY

Please check the box ☒ if other immediate family members have had a history of these problems

	Mother	Father	Brother 1	Brother 2	Sister 1	Sister 2	Other Relatives
Fill in this Person's Name							
Chronic Atopic Dermatitis or Eczema							
Food Allergies							
Allergic Nasal or Eye Symptoms							
Allergic or Non-allergic Asthma							
Recurrent Hives or Deep Swellings							
Recurrent Middle Ear or Sinus Problems							
Recurrent Migraine Headaches							
Insect Sting Allergies							
Other Health Issues:							

ENVIRONMENTAL EXPOSURES

Where were you born? ______________________________ Where have you lived in your life? ______________________________

______________________________ Where is your current home located? ______________________________

In what year was your home built? ________________ Number of people who currently occupy this home?______________

How many are adults?______________

Please check YES ☒ for the answers that best describe the basic structure, heating, cooling and filtering systems for this home. Leave the boxes blank if they do not relate to your current home.

What is the structure of your current home?	How do you currently heat your home?	How do you cool and/or filter your home?
☐ Single family home	☐ Electric baseboard heat	☐ Central air conditioner
☐ Condominium	☐ Electric wall heaters	☐ Window-insert air conditioner
☐ Duplex	☐ Steam radiators	☐ Opening the windows
☐ Apartment	☐ Hot water radiators	☐ Central humidifier
☐ Dormitory room	☐ Fireplace insert/woodstove	☐ Room-size humidifier
☐ Manufactured home	☐ Pellet stove	☐ Central air filter
☐ Trailer	☐ Propane stove	☐ Room-size air filter
☐ Lake cabin	☐ Gas forced air heat	☐ Fans
☐ Other:	☐ Electric forced air heat	☐ Other:
	☐ Heat pump	
	☐ Other:	

Please check ☒ if you have <u>ever used</u> tobacco products. Leave this section blank if you have never used tobacco products.

☐ For how many years did you use tobacco? _____years. What type of tobacco product?___________ Cigarettes per day?______
If you no longer use tobacco, what year did you quit? _________

If you still smoke, how many cigarettes do you smoke per day (on average)? ______ cigarettes/day
How many smokers currently live in this home? _______Where do they smoke (circle the correct response): Indoors/ Outdoors/ Both
Please check YES ☒ for the most common air quality problems in your home. Also check YES ☒ for the animals that currently reside inside or outside your home. Leave the boxes blank if they do not apply to your current home.

WHAT ARE SOME POTENTIAL AIR QUALITY PROBLEMS?	INSIDE PETS/ANIMALS	OUTSIDE PETS/ANIMALS
☐ Indoor cigarette smoke	☐ Birds (number)	☐ Birds (i.e., chickens) (number)
☐ Wood smoke	☐ Cats (number)	☐ Cats (number)
☐ Scented candles	☐ Dogs (number)	☐ Cattle (number)
☐ Incense odors	☐ Gerbils (number)	☐ Dogs (number)
☐ Irritating or noxious odors	☐ Guinea pigs (number)	☐ Goats (number)
☐ Excessive dampness	☐ Hamsters (number)	☐ Horses (number)
☐ Water damaged areas	☐ Pet mice (number)	☐ Llamas, alpacas (number)
☐ Moldy or musty odors	☐ Pet rats (number)	☐ Rabbits (number)
☐ Visible mold in some areas	☐ Rabbits (number)	☐ Sheep (number)
☐ Pet odors	☐ Reptiles: (number)	☐ Other:
☐ Other:	☐ Other:	☐ Other:

Current Work Exposures: (if applicable)

Where are you employed currently? ______________________

Job title: ______________________

Are there any workplace exposures that cause symptoms? ______________________

Current School Exposures: (if applicable)

What is the name of your school? ______________________ Grade: __________

Are there any school exposures that cause symptoms? ______________________

Current Daycare or Preschool Exposures: (if applicable)

What is the name of your daycare or preschool? ______________________

How many days/week do they usually attend this facility? __________ How many hours/day do they attend? __________

How many other children are at this facility (estimate)? ______________________

Are there any exposures here that cause symptoms? ______________________

List your <u>Current Prescription and Nonprescription Medication Names</u>, including all topical ointments, creams, herbal remedies, and oral supplements. Write down the <u>Usual Dosage and Frequency</u>. For the <u>Source of this Medication</u>, include the name of the person providing this prescription, or write "OTC" if it is available "Over-The-Counter" or without prescription.

CURRENT MEDICATION NAME	USUAL DOSE AND FREQUENCY	SOURCE OF THIS MEDICATION (PRESCRIBER)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY

Please check YES ☐ for any symptoms or surgeries you have had in the past. Leave these boxes blank if you feel these do not apply.

Medical History		
☐ Acid reflux	☐ Coronary artery disease	☐ Myocardial infarction
☐ Allergic rhinitis	☐ Depression	☐ Nasal fracture
☐ Allergies	☐ Deviated nasal septum	☐ Peptic ulcer disease
☐ Anemia	☐ Ear infections, acute	☐ Pleurisy
☐ Anxiety	☐ Ear infections, chronic	☐ Pneumonia
☐ Arthritis	☐ Eczema	☐ Renal disease
☐ Asthma	☐ Elevated lipids	☐ Seizure disorder
☐ Atopic Dermatitis	☐ Gallbladder disease	☐ Sinusitis
☐ Bronchitis	☐ GERD	☐ Sleep Apnea
☐ Cancer	☐ Headache, migraine	☐ Stroke
☐ Cardiovascular disease	☐ Headaches	☐ Tonsillitis
☐ Contact dermatitis	☐ Hepatitis/liver disease	☐ Tuberculosis
☐ COPD	☐ Hypertension	☐ Urticaria
		☐ Other:
Surgical History (and date of surgery performed)		
☐ Adenoidectomy	☐ Cholecystectomy	☐ Knee replacement
☐ Angioplasty	☐ Gastric bypass	☐ Myringotomy
☐ Appendectomy	☐ Hernia repair	☐ Thyroidectomy
☐ Back surgery	☐ Hip replacement	☐ Tonsillectomy
☐ Blood transfusion	☐ CABG	☐ Other:

OTHER SYMPTOMS

Please check YES ☐ for any SYMPTOMS you care experiencing currently. Leave these boxes blank if you do not feel that you are experiencing these symptoms.

CONSTITUTIONAL	HEMATOLOGIC/LYMPHATIC	NEUROLOGICAL
☐ Fatigue	☐ Lymphadenopathy	☐ Dizziness
☐ Insomnia	☐ Other:	☐ Fainting
☐ Malaise		☐ Headache
☐ Weight gain	**CARDIOVASCULAR**	☐ Seizures
☐ Weight loss	☐ Hypertension	☐ Other:
☐ Other:	☐ Arrhythmia	
	☐ Murmur	**PSYCHIATRIC**
METABOLIC/ENDOCRINE	☐ Edema	☐ Anxiety
☐ Decreased activity	☐ Syncope	☐ Depression
☐ Insomnia	☐ Palpitations	☐ Other:
☐ Diabetes	☐ Other:	
☐ Hypothyroid		**GENITOURINARY**
☐ Hyperthyroid	**REPRODUCTIVE**	☐ Urination at night
☐ Osteoporosis	☐ Pregnant	☐ Pain with urination
☐ Osteopenia	☐ Breast feeding	☐ Frequent urination
☐ Other:	☐ Post-menopausal	☐ Urinary incontinence
	☐ Other:	☐ Other:
MUSCULOSKELETAL		
☐ Joint pain		**IMMUNOLOGY**
☐ Joint swelling		☐ Recurrent infections
☐ Other:		☐ Other:

Who is your PRIMARY CARE PROVIDER? ______________________________

List any other MEDICAL OR DENTAL SPECIALTY CONSULTANTS that you have seen: ______________________________

____

List any past HOSPITALIZATIONS that you have not yet mentioned (including the year): ______________________________

____

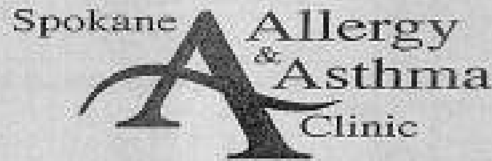
List any past SURGERIES that have been performed: ______________________________

____

List any significant PAST MEDICAL PROBLEMS. These are problems that are now RESOLVED, and require no futher treatments or monitoring. List any past CANCER history here: ______________________________

Is there any other question or concern that you would like to discuss with your Provider during this initial evaluation? ______________________________

____



Steven Kernerman, DO   Kerry Drain, MD   Ronald England, MD   Rayna Doll, DO

Mariya Baldwin, ARNP   Tamara Zey, ARNP

Patient Out of Pocket Cost Estimate Worksheet

Thank you for allowing us to help your allergy and asthma concerns. This worksheet is provided to allow you to estimate the expected out of pocket cost for your services. Please complete this form prior to your appointment to better understand what could be your financial responsibility for your visit. We are happy to set up payment arrangements as needed over a six-month time period. Please contact the billing and verification staff with any additional questions and we will be happy to assist.

1. **When calling your insurance's member services please be sure to note your representative's name and call reference number (this phone number is most commonly found on the back of your insurance card), and please ask the following:**

a. Do I have Asthma/Allergy benefits? Is Spokane Allergy and Asthma in Network? **(Y/N)**

b. Do these services require a referral from my Primary Physician? **(Y/N)**

c. Do I have a deductible? **(Y/N)**

I. What is my deductible? (______________)
II. What has been met of the deductible? (______________)
III. Do my allergy benefits apply to my deductible? **(Y/N)**

d. Do I have a coinsurance? **(Y/N)**

I. What is it? (____%)
II. Do my allergy benefits apply to my coinsurance? **(Y/N)**

e. Does my Office Visit Charge apply to my deductible or is it covered by my copay (*please note that all testing will be unique from the office visit charge and may process differently than testing according to your benefits*)? (____________)

f. What is my Out of Pocket Maximum? (__________) What has been met (_______)

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2. Sometimes member services will request testing procedural codes. Unfortunately, we cannot with 100% certainty know what testing will be recommended during your appointment, however the codes below are the most common tests performed. Please remember that there are two full time billing specialists on site to help you with any questions that may arise if additional testing is recommended during your appointment.

Commonly Used Allergy/Asthma Testing CPTs

94010 – Baseline Spirometry	89190 – Nasal Smear
94060 – Pre-and Post-Spirometry	95004 – Skin Prick Tests (1 item per test)
95012 - FENO	95024 – Intradermal Tests (1 item per test)
95017 – Venom Allergy Test (1 item per test)	95018 – Drug Allergy Test (1 item per test)
95044 – Patch Allergy Testing (1 item per test)	

3. If you have more then one insurance policy be sure to check with both insurance companies to make sure that they are aware of one another and that Coordination of Benefits has taken place or your claim may not be paid.

As always, we are happy to help with any questions you may encounter along the way. Please contact the verification team for any additional questions prior to visit. Thank you and we look forward to seeing you at your appointment.

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