Spokane Allergy & Asthma Clinic

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

1330 N Washington St., STE 4200, Spokane WA 99201 Phone: 509-747-1624, Fax: 509-747-6774

New Patients

Please have paperwork filled out BEFORE arriving for your appointment, OR arrive ½ hour before your scheduled appointment time, to do your paperwork in the office.

You may return your completed paperwork by fax 509-747-6774, or in person, prior to your appointment. We will scan your forms into your chart and it will be ready when you get here for your scheduled appointment.

If you arrive, WITHOUT THE COMPLETED PAPERWORK, your appointment will be rescheduled for another day. Please be prepared!

WHAT TO BRING TO THE APPOINTMENT:

- Completed, filled out and signed forms
- Co-Pay
- Current insurance card(s)
- Photo identification (driver's license or ID)
- If under the age of 18, must be accompanied by parent/guardian

.

SPOKANE ALLERGY & ASTHMA CLINIC

PATIENT INFORMATION:

☐ New patient ☐ Name change ☐ Address change ☐ Insurance change

Patient: _____
First Middle Last

SSN#: _____ Date of Birth: _____Age: _____ Sex: ☐ male ☐ female

Home Address: Street: _____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: _____ Ethnicity: American Indian or Alaska Native Race: Not Hispanic or Latino

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

Name: _____ Date of Birth: _____
First Middle Last

Address: _____City: _____State: _____Zip: _____

Home Phone: _____Work phone: _____Cell: _____

Relationship to Patient: _____ SS#:_____

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'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: _____

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: _____ Phone #:_____

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

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 you have seen: _____

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

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

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

Names of any previous 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? _____

Names of 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 is your current home located?

Where have you lived in your life? _____

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

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

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: _____

Spokane Allergy & Asthma Clinic

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.*

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 7, 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

1330 N. Washington St, Suite 4200
Spokane, WA 99201
Phone: 509-747-1624 Fax: 509-747-6774

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? ☐

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 & Asthma Clinic

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 (_____)

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

Spokane Allergy & Asthma Clinic

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

Mariya Baldwin, ARNP Tamara Zey, ARNP

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

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

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 arrive 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.

CLINIC HOURS:

Monday -Friday: 7:45am - 11:45am
12:45pm - 4:45pm

SHOT CLINIC HOURS:

Monday: 8:00am - 4:15pm

Tuesday - Thursday: 8:00am - 11:15am
& 1:00pm - 4:15pm

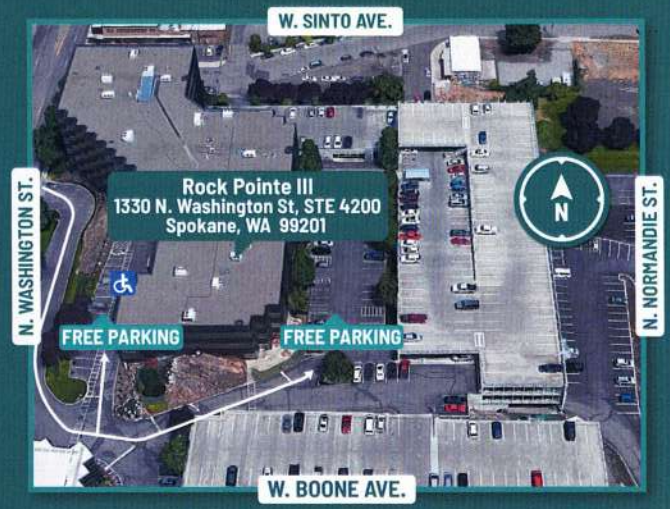
Friday: 7:00am - 4:15pm

Find us on

DIRECTIONS

Travel north on North Washington Street and make right turn into side entrance. Please reference the map below to find free parking and suite.

HANDICAP PARKING IS AVAILABLE.



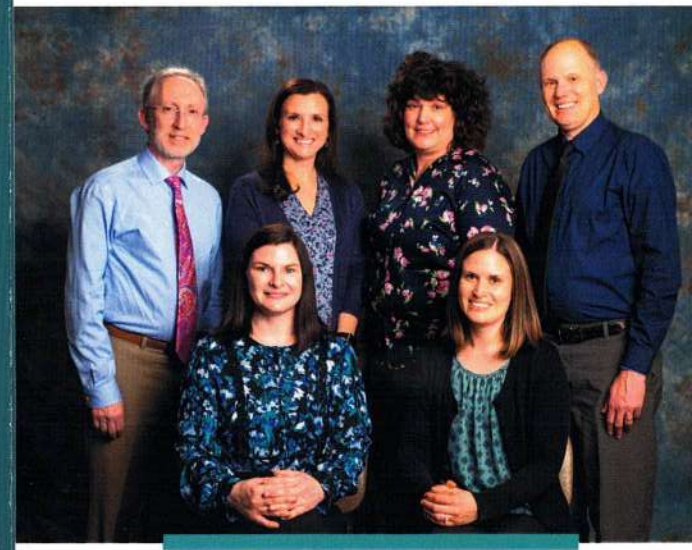
Spokane Allergy & Asthma Clinic

Rock Pointe III
1330 N. Washington St. • Ste. 4200 • Spokane WA 99201

Tel: 509-747-1624
Fax: 509-747-6774

SpokaneAllergy.com

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.

Rock Pointe III
1330 N. Washington St. • STE 4200 • Spokane WA 99201

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 this 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 an 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™
- Diphenhydrarnine

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 & Asthma Clinic

Some medications can interfere with allergy skin testing. In order for us to obtain the most accurate results, **please stop taking antihistamines used for allergy treatment 4-5 days prior to New Patient Appointments or prior to Skin Testing.** If you have a question about whether it is safe for you to stop your antihistamine, please contact your prescribing physician.

Common medications containing antihistamines may include:

Allegra™, Allegra-D, Aller-fex™ (fexofenadine)

Zyrtec™, Aller-tec (cetirizine)

Claritin™, Claritin-D, AllerClear, Alavert™ (loratadine)

Clarinex™ (desloratadine)

Benadryl™ (diphenhydramine)

Xyzal™ (levocetirizine)

Atarax™**, Vistiril**™ (hydroxyzine)

Allerest™, Chlor-Trimeton™ , Sinutab™, Brexin LA™, Tussionex (chlorpheniramine)

Actifed™

Advil™ (PM, Allergy, Cold/Sinus)

Ala-Hist™

Aleve Cold™

Alka Seltzer Plus/Cold/PM™

Allergy Relief Med

Benylin™ Cough Med

carbinoxamine

Comtrex™

Contac™

CoricidinTM

Co-Tylenol

Cough medications with antihistamines

Dimetane

Dimetapp™, Bromfed™, Allent (brompheniramine)

Dramamine™, Antivert, Bonine (meclizine)

Excedrin PM™

Extendryl™

Marezine™, Valoid™, Nausicalm™ (cyclizine)

Nighttime sleep aids (Simply Sleep, Unisom, doxylamine, Doan's PM)

Nytol™

Nyquil™

Pediacare™ Cough and Cold

Periactin™ (cyproheptadine)

Phenergan (promethazine)

phenylephrine

phenyltoloxamine

polyhistine

Prudoxin™, Zonalon™, Silenor™, Sinequan™ (doxepin)

Robitussin™ (many forms)

Rondec™

Rynatan™

Sudafed Cold and Allergy™

Tanafed™

Tavist™ (clemastine)

Theraflu™

Torecan™ (thiethylperazine)

Triaminic™

Pyribenzamine™ (tripelennamine)

Tylenol Cold and Sinus™ (chlorpheniramine)

Vicks 44M™

4-17