

1505 Franklin Rd. SW Roanoke, VA 24016 T (540) 343-7331 F (540) 343-7349

Patient Information Sheet

Lynchburg

2015 Tate Springs Rd. Lynchburg, VA 24501 T (434) 846-2244 F (434) 846-0602

Salem

3529 Keagy Rd. Salem, VA 24153 T (540) 343-7331 F (540) 725-1356

Account:_

Patient's Name (Please print ar	nd include middle initial)	Sex	Marital Status		Age	Home Phone		
		M F	S M W	D Sep				
Date of Birth	Social Security #	Race/Ethnicit			Į.	Cell Phone		
Street Address	Apt. Numb	ber City		State	Zip Code	Email Address		
Primary Care Physician		Address				Phone		
Timal y Care I nysician		ridaress				Thone		
Referring Physician		Address		Phone				
referring r nysician		ridaress		Thone				
Emergency Contact		Address				Phone		
Emergency Contact		Address				FIIOIE		
II 1: 1 5: -1t -bt								
How did you find out about ou	romce?							
			Otl	her (Please e	xplain):			
		ICD 4					_	
D-tit' Γ		If Patient	t is an Adult			Wash Diama		
Patient's Employer						Work Phone		
Spouse's Name		Spouse's Date	e of Birth	Spouse's S	Social Security #	Spouse's Cell Phone		
Spouse's Employer		•				Spouse's Work Phone		
		If Patien	t is a Child					
Father's Name		Father's Date		Father's S	ocial Security#	Father's Cell Phone	_	
Father's Address (If different f	rom patient's)	I	Employer			Father's Work Phone	_	
	· · · · · · · · ·		1 .7.					
Mother's Name		Mother's Date	a of Dirth	Mother's	Social Security #	Mother's Cell Phone		
Moulet's Name		Wiother's Date	e or Birui	Wiotifet S	social security #	Wother & Cent Filone		
7.7 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.								
Mother's Address (If different	from patient's)	Ŀ	Employer			Mother's Work Phone		
		Insuranc	e Informatio	n		*We will only bill Primary and Secondary		
Name of Primary Insurance	Policy Holder		Birth Da	ate	Policy or ID#	Group #		
Policy Holder's Address (If di	ferent from patient's)				Relationship to pat	ient		
	•							
Name of Secondary Insurance	Policy Holder		Dinth D	ata	Policy or ID #	Group #		
ivame of Secondary Insurance	Policy Holder		Birth Da	ate	Policy of 1D#	Group #		
Policy Holder's Address (If di	ferent from patient's)			Ţ	Relationship to pat	ient		
							_	
Cianotura:						Doto:		



NEW PATIENT EVALUATION SECTION I: CLINICAL HISTORY

Nurse's Initials:_____

1. Name:					Age:	Date:		
Referring Physician: Office Location:								
2. Chief Complaint: Describe in the patient's own words, the problems that bring them here for evaluation.								
a) Ha	ave your	health problems caused you to mi		ool days	over the	e) When did the latest attack star	t and end?	
pa	st year?	If yes, how many?						
ь) ц	ovo voue	family members missed any days	of work or sobool 1	20001160	of wour	f) How often do you have these	problems?	
	ave your alth prob			because	or your	1) 110 W often do you have these j	prooreins.	
	um proc	11 y es, 110 W 111111y V						
c) Ha	ave you r	equired emergency treatments or		his?		g) How long do they last?		
		How many times in the past	year?			h) Which of these symptoms do	you have	
d) W	hen did s	our main symptoms first appear?				every day?	•	
		f Present Illness: Oculo-Nas	al		•	Present Illness: Pulmonary		
a)	Do you	have any eye or nasal symptoms? If no, please skip i	item #4 helow	a)	Do you r	have any chest symptoms? If no, please skip iter	n #6 below	
b)	How lon	ig have you had these?	nem #4 below	b)	How lon	g have you had these?	II #O OCIOW	
		ose eye or nasal symptoms th				se "chest-related" symptoms tl	at apply:	
Yes	None	Circle those symptoms that a	are most severe	Yes	None	Circle those symptoms that are	most sovere	
res	None	a) Runny nose / clear, watery	l most severe	1 68	None	a) Chest tightness	most severe	
		b) Blockage (plugged up)				b) Chest congestion		
		Trouble with nose breathing				c) Frequent cough		
		c) Sneezing spells or fits				Nocturnal cough		
		d) Trouble smelling things				Cough with exertion		
		, , , , , , , , , , , , , , , , , , , ,				Cough with laughing or screaming		
		e) Post-nasal drainage						
		Thick, discolored drainage				Cough at rest		
		Thin, clear, watery drainage				Coughing up discolored mucus		
		f) Itching of eyes				Coughing up blood		
		Of ears				d) Difficulty walking up stairs		
		Of nose				Difficulty breathing		
		Of throat				Trouble taking a deep breath		
		Of roof of mouth				Shortness of breath		
		g) Dryness or nose bleeds				Difficulty running		
		h) Frequent colds or infections				Difficulty walking around		
		Earaches or ear infections				Easy fatigability		
		Sinus infections				e) Ever diagnosed as asthma		
		i) Throat tickle with cough				f) Do you ever wheeze?		
		j) Throat or face swelling				Hospitalized for wheezing		
		k) Eyes - burning				Wheezing attacks		
		Watery				Wheezing with colds		
		Puffy or swollen eyes				Wheezing with exercise		
		1) Frequent headaches				Wheezing at night		
		Sinus headaches				Wheezing at rest		
		Migraine headaches				g) Snoring		
		Tansion handaches				h) Mouth breathing		

Patient Name:							ate:]	Nurse:			2	
7. Do you have any skin problems?						C	neck le	vel of s	severit	v ->	No	ne	Mild	Mod	Severe
If no, please mark "None" in the boxes to the right							alized i		<i>y</i> – /	110	IIC	MIII	WIGG	Bevere	
a) How long hav	e you had	these?			if you	-	Swelli								
have hives, we			ria, ple	ase cor	nplete	-			nic der	matitis					
the "Hives Qu	estionnaire'							nfection				+			
b) Please describ	oe your ski	n problem	:					vith me				+			
						f)	Poison	ivy / o	ak / su	mac					
						g)	Psoria	sis							
						h)	Seborn	hea				\exists			
8. Do your symptoms	vary with	the season	ıs:	I	f no, te	ll us if	you ha	ve then	ı all ye	ar or go	o to sec	ction	#9		1
Mark the time of year vi	vhen you ha	ave the	All year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oc	t Nov	Dec
Nasal Symptoms															
Eye symptoms															
Chest symptoms															
Skin problems															
Other: (specify)															
9. Please list any med										nedicat					1
take on a regular basi you need more space, list						rea	ctions	?]	If no, p	lease sl	kip th	iis secti	on.	
Medication:	them in the	Dose tak		Last		Me	Medication:					Reaction		When	
11. Have you ever bee	en evaluate	ed for aller	gies in	the pa	st?										
a) If yes, to what tes	ts were you	found to be	allergic'	?			Oid you Iow lon			injection they he					
						v	Vhen we	ere they	stoppe	d?					
12. Family Histor		hose medic				may ru	n in yo	ur fam	ily.		to the	illnes	ss.		
Aspirin reactions			*		•	1	fever								
Bronchial asthma						Hiat	al hern	ia							
Blocked nose						Hive	es								
Diabetes						Mig	raine h	eadach	es						
Eczema						Sinu	sitis								
Emphysema						Tuberculosis									
Food allergy						Othe	er (spec	cify)							

Patient Name: Date:	Nurse:	
13. Check those factors below that make your symptoms worse	,	
a) Weather changes: Rain, cold fronts, thunderstorms, wind		
b) Humidity: High (dampness) or low (dryness)		
c) Tobacco smoke		
d) Smog/air pollution		
e) Cold air: Inside (air conditioning) or outside		
f) Heat: Inside or outside		
g) Perfumes, powder, detergents, air fresheners, hairspray		
h) Fumes: Paint, fuel, insecticides		
i) Bright sun		
j) Inside dust: Vacuuming, cleaning, sweeping, old books		
k) Outside dust		
1) Stress, worry		
m) Exercise or exertion		
n) Laughing		
o) Grass or hay mowing, fresh cut grass		
p) Tree pollen		
q) Mold: Raking leaves, musty basements, mildew, fungi		
r) Weeds		
s) Animals (list):		
t) Feathers		
u) Other:		
14. Home/Work Survey: Circle those that apply. If "Yes," fill in the blank a	as appropriate.	
Occupation:		
Do any conditions at work make your symptoms worse?		
Hobbies:		
Does anything related to your hobby make your symptoms worse?	What?	
Home heating:		
Home cooling:		
Type of bed: Mat	tress cover:	
Dust catchers:	tiess cover.	
Solid flooring: Window cove	ering:	
Carpets:		
Pets:		
Are the pets indoor or outdoor?		
Are you exposed to any other birds or animals?		
Does anyone who lives at home smoke? Who?		
Does anyone who lives at home smoke? Who? If you have smoked, how much and how long?		
Are there any industries around that house that bother you?		
Other		

15. If female, are you pregnant or trying to achieve pregnancy? LMP:	Patien	t Name:		Date:		Nurse:	4
a) Do you have any problems with any foods? By the problems with insect stings? What kind? Have you ever had any reactions that were more that large local swelling? If "Yes," please complete the "Bee Sting Anaphylaxis Questionnaire." 17. Neonatal History: (Circle appropriate answer) a) Were you breast-fed, bottle-fed, or both? b) Did you have problems with baby formulas? c) Were you premature? d) Did you have newborn breathing problems? 18. Immunizations: a) Initial childhood immunization series c) Chicken pox vaccine d) MMR booster in 10 years c) Chicken pox vaccine d) MMR booster d) MMR booster e) Prevnar d) Mind problems 19. Check those medical conditions which you have had in the past series d) Hindurast (due of last dose) 19. Check those medical conditions which you have had in the past series e) Hindurast (due of last dose) 19. Other from any of the following: Frequency episode ploate of last law you had any of the following episode episode episode Nasal polyps Bronchitis Power of the following problems Ridney discusses Bladder problems Kidney disease Muscle or back trouble Arthritis Cancer Tendonitis or joint trouble Tregular heartheat Heart disease/rheumatic fever/murmur High blood pressure High blood pressure High blood pressure High blood pressure Substance abuse Dispression/nervous disorders Dizziness or vertigo Bleeding problems or easy bruising Heatal hermize/GERD Hysterectomy Selections Sinus CT scan: Normal: Dizziness or vertigo PE car ubus, sonsil or adenoidectomy PE	15. l	f female, are you pregnant or trying	to achieve pr	regnancy?		LMP:	
b) Do you have any problems with insect stings? Have you ever had any reactions that were more that large local swelling? If "Yes," please complete the "Bee Sting Anaphylaxis Questionnaire." 17. Neonatal History: (Circle appropriate answer) a) Were you breast-fed, bottle-fed, or both? b) Did you have problems with baby formulas? c) Were you premature? d) Did you have newborn breathing problems? 18. Immunizations: a) Initial childhood immunization series b) Tetanus booster in 10 years c) Chicken pox vaccine d) MMB booster c) Chicken pox vaccine d) MMB booster d) Hepatitis B series i) Influenza: (due of last dose) 19. Check those medical conditions which you have had in the past Review of Systems: Do you suffer from any of the following: Frequency Sinusifis Do you suffer from any of the following: Frequency Sinusifis Emphysema Pneumonia Tuberculosis Asthma attacks Diabetes Bladder problems Muscle or back trouble Carpal tunnel syndrome Arthritis Cancer Tendonitis or joint trouble Carpal tunnel syndrome Arthritis Cancer Tendonitis or joint trouble Treadiant for point trouble Treadiant for point trouble Treadiant for point trouble Addiction Substance abuse Substa	16. A	Ancillary Allergy History:					
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Irregular heartbeat High blood pressure Thyroid Alcohol use Addiction Substance abuse Depression/nervous disorders Dizziness or vertigo Sinus x-rays: Normal: Dizziness or vertigo Sinus CT scan: Normal: Bleeding problems or easy bruising Hiatal hernia/GERD Hysterectomy Frequent heartburn or stomach ulcers Bedwetting PE ear tubes, tonsil or adenoidectomy Seizures/convulsions Hair loss 19. Additional Comments:	Arthr	tis				Cancer	
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1505 Franklin Rd SW Roanoke, VA 24016 (P) (540) 343-7331 (F) (540) 343-7349

Lynchburg

2015 Tate Springs Rd. Lynchburg, VA 24501 (P) (434) 846-2244 (F) (434) 846-0602

Salem

3529 Keagy Rd Salem, VA 24153 (P) (540) 343-7331 (F) (540) 725-1356

Patient Financial Policy

Thank you for choosing Allergy & Immunology, PLC (the Asthma and Allergy Center) as part of your healthcare team. We are committed to building a successful physician-patient relationship with you and your family. Your understanding of our financial policy is an important piece in building that relationship. Please ask our staff If you have any questions about our policies or about your responsibilities.

We require that all patients complete the Patient Financial Policy prior to seeing the provider. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

1. PAYMENT is due at the time of service unless other financial arrangements have been made in advance. We require all patients to pay their copay and/or coinsurance payment at the beginning of each visit. After the conclusion of each visit, the patient will be billed for any remaining balance, including, but not limited to the patient's deductible and any uncovered services as contractually allowed. The patient, or responsible party if patient is a minor, is ultimately responsible for payment for any professional services rendered, regardless of insurance.

By signing this form, you are acknowledging that you understand and authorize that, when requested by you, Allergy & Immunology, PLC will send emailed receipts of payment. These receipts will be transmitted over an unsecure channel and there is a chance they may be intercepted by a 3rd party.

2. INSURANCE It is the responsibility of the patient to provide our office with current insurance information and to complete any forms necessary to expedite payment by the insurance provider. The patient is expected to present an insurance card at each visit. A quote of benefits provided by Allergy & Immunology, PLC is not a guarantee of benefits or payment. Insurance coverage is verified as a courtesy and does not guarantee payment. Not all insurance plans cover all services.

Your insurance policy constitutes a contract between you and the insurance provider. Some insurance plans require precertification or a referral from a primary care physician to cover our services. It is the responsibility of the patient to obtain any precertification or referrals necessary for payment. The patient, or responsible party if the patient is a minor, is ultimately responsible for all charges. Please check with your insurance carrier to verify coverage.

It is the policy of Allergy & Immunology, PLC to file insurance claims with a primary carrier and one additional secondary carrier. Any additional claims will have to be submitted by the policy holder.

By signing below, you also request that all payments of authorized Insurance Company benefits

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be made either to you or on your behalf to Allergy & Immunology, PLC for any services furnished to the patient by this office. Regulations pertaining to Medicare assignment of benefits apply.

- 3. **RETURNED CHECKS** will incur a \$50 service charge payable by cash, credit, or money order. This amount will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash or credit only basis following any returned check.
- 4. **OUTSTANDING BALANCE** It is the policy of Allergy & Immunology, PLC that all past due accounts will be sent two statements. If payment is not made on the account, a single phone call will be made to attempt to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney.

In the event an account is turned over for collections, the individual financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs. By signing this form, you are acknowledging and authorizing the Collection Agency to contact you via phone (including cellphone), text message, or email with an automated message when applicable. You are acknowledging that you will be responsible for any additional fees issued by your wireless carrier as a result of these calls or messages. You are also acknowledging that you may be required to pay upfront for all services rendered.

- 5. **MEDICAL RECORDS** requests are processed in timely manner, in accordance with both federal and state law. Patients requesting copies of their medical records will be assessed a charge of \$0.25 per page with a \$5 minimum charge.
- 6. **CANCELLATIONS and MISSED APPOINTMENTS** Allergy & Immunology, PLC strives to provide prompt and timely care to all patients. No-Shows or late cancellations prevent other patients from receiving care. Allergy & Immunology, PLC requires 48 hours notice to reschedule appointments. Appointments rescheduled without this notice period may incur a \$25 charge. Missed appointments may be charged a \$60 fee. These charges are the responsibility of the patient and are not covered by insurance.
- 7. **MINORS** If a patient is a minor, the parent or guardian who authorizes treatment will be held financially responsible for all professional services provided to the patient by Allergy & Immunology, PLC. If a court order is in force that outlines other arrangements, it must be provided promptly to Allergy & Immunology, PLC.

I, the undersigned, acknowledge that I have read the statements above and agree to the terms and
conditions. I accept responsibility for payment of all professional services provided to the patient by
Allergy & Immunology, PLC.

Patient Name:	DOB:
Guardian (if applicable):	Relationship:
Signature:	Date:

By selecting, I am acknowledging that my electronic signature is legally binding.



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Privacy Policy Acknowledgement Form

Patient Name:	Date of Birth:
Guardian/ Representative (if applicable):	
Relationship to Patient:	
My signature below indicates that I have been prov Center's Notice of Privacy Practices.	vided with a copy of the Asthma & Allergy
Cionatura:	Date



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Authorization for Use or Disclosure of Information

Patient Name:		Date of Birth:
Guardian/ Representative	(if applicable):	
Relationship to Patient:		
I, the undersigned, hereby protected health information Appointments		Allergy Center to disclose the following Labs and other test results
Medications	Shot and Vial Histo	ory
To the following entities:		
For the following use or p	urpose(s):	
Ongoing Healthcare		
I understand that I have the written notification to Jaso revocation is not effective or disclosure of the PHI. I may be a charge associated disclosed pursuant to this a no longer be protected by my treatment, payment, en whether I provide authoriz I understand that I have the Inspect or copy the	e right to revoke this author on Call at the Roanoke add to the extent that The Astifurther understand that, ind with copying my records authorization may be subjected federal or state law. The Annollment in a health plan of eation for the requested used e right to:	sed as permitted under federal law (or state
law to the extent the Refuse to sign this	ne state law provides greate authorization.	er access rights.)
Signature:		Date: