New Patient Packet

Thank you for making your first appointment with AllerVie Health!

AllerVie Health and our Board-Certified Allergists and Immunologists are committed to helping patients achieve and maintain optimal health and quality of life -- free from the symptoms and suffering of allergies, asthma, and related immunological conditions.

Please complete the new patient packet following this letter, and bring it along with your insurance and driver's license to your first appointment. Please keep in mind that your first appointment can be lengthy due to the extensive information you will be provided to assist you in managing your continued good health.

Here are a few things to know for your first appointment:

- **Discontinue all Antihistamines FIVE days prior to your appointment.** Common medications containing Antihistamines are Benadryl, Triaminic, cough and cold medicines. Do not stop taking Singulair or asthma inhalers. For a complete list, visit **allervie.com** and click on **For Patients**.
- Please wear clothing that will allow allergy testing with ease. A two piece outfit, ex., shirt and pants work best.
- We love children! However, if you are being allergy tested you will need to remain stationary and it will be difficult to keep an eye on small children.
- We have Wi-Fi available in most locations for your convenience.
- Your visit as a new patient can last up to a few hours depending on testing needs. Please be prepared to stay at our office for the duration of your visit.
- **Remember that in order to be tested on the day of your initial visit you will need to discontinue certain medications five days prior to your appointment.** If you are concerned or have questions about which medications to discontinue, please do not hesitate to call our office.

Should you need to cancel or reschedule your appointment, please contact our office 24 hours before your appointment to avoid any cancellation fees, up to $50.

We look forward to serving you and helping you find relief from your allergy symptoms!

Sincerely,
The AllerVie Health Team

Thank you for choosing our practice. We are committed to providing you with quality and affordable healthcare. Below is information regarding our privacy policy, consent for treatment and payment policy as it relates to patient and insurance responsibility for services rendered. Please review it, then sign/accept in the space provided. A copy will be provided to you upon request. If you have any questions please feel free to contact our office. Thanks so much for being our patient.

Acknowledgment Form for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge the use or disclosure of my Protected Health Information (PHI) by AllerVie Health and its Subsidiaries and Partners for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of AllerVie Health. I understand that diagnosis or treatment of me by the healthcare providers of AllerVie Health may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. AllerVie Health is not required to agree to the restrictions that I may request. However, if AllerVie Health agrees to a restriction that I request, the restriction is binding on AllerVie Health and Healthcare Providers of AllerVie Health. I have the right to revoke this consent, in writing, at any time, except to the extent that Healthcare Providers of AllerVie Health or AllerVie Health has taken action in reliance on this consent.

My “Protected Health Information” means health information, including my demographic information, collected from me and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices for AllerVie Health is provided in the patient reception area and I understand I have a right to review the Notice of Privacy Practices prior to signing this document. I also understand a personal copy of AllerVie Health’s Notice of Privacy Practices can be provided to me for review upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of AllerVie Health.

AllerVie Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by reviewing the notices provided in patient reception area or by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Authorization and Consent for Treatment

The undersigned agrees, whether he or she signs as agent or as a patient, that in consideration of agreed upon services to be rendered, including allergy extracts and injections, by AllerVie Health to the patient, he or she hereby obligates himself or herself, assumes financial responsibility, and agrees to the AllerVie Health payment policy as outlined below regarding all charges for such services incurred by said patient. The undersigned consents to treatment as determined and discussed with and agrees to medication history review and reconciliation. The undersigned also specifically agrees that AllerVie Health can use PHI to communicate via phone, email or text for essential follow up needs, or appointment reminders, as well as conduct analysis for internal business purposes, customize patient needs for services and create de-indentified information to use and disclose in anyway permitted by law, including to third parties in connection with commercial and marketing efforts. This office will file and collect from insurance when insurance benefits are present. I hereby authorize AllerVie Health to use “Signature on File” in lieu of an original signature for all medical claims submitted for services rendered to patient. I acknowledge that all information regarding my identity is correct and accurate to my knowledge. By signing/accepting this document I understand that I am held accountable for any false information which could result in a fine or penalty and should notify AllerVie Health if any of my information should change or if my identity is compromised or stolen.

Payment Policy

ALL DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE ARE DUE AT THE TIME OF SERVICE

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals: If you have an insurance plan with which we are contracted, you may need a referral authorization from your primary care physician/ pediatrician. ***If we have not received a referral at least 24 hours prior to your arrival at the office, your appointment may be rescheduled.***

Labs: All lab work is performed by an outside reference lab. AllerVie Health does not verify benefits coverage on lab services. Patients will receive a bill directly from the lab regarding any balances after insurance is filed. If you would like to check your lab benefits prior to these services being rendered, please inform the nurse.

Co-payments and Deductibles: All co-payments, deductible and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance: All patients must complete our patient information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment: We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Patient Statements: If you have an unpaid balance, you will receive a statement by mail or email monthly. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be will be turned over to an attorney or collection agency for collections. All payments made go to the oldest outstanding balance.

Self Pay: We accept self-pay for our services at select AllerVie locations. If you are uninsured or wish to self-pay for our services, we will also provide financial counseling for you at your appointment. Payment is due in full at the time of service.

No Show Fee: Should you need to cancel or reschedule your appointment, please contact our office 24 hours before your appointment to avoid any cancellation fees, up to $50.

By accepting the terms outlined above I understand that all bills are payable upon presentation, and that I, not the insurance company, is ultimately responsible for payment of the services.

Signature and Acceptance

I understand that selecting Agree and entering name/initials via portal, or signature below constitutes a legal signature confirming that I acknowledge and agree to the above policies set forth by AllerVie Health.

Patient or Legal Guardian/Responsible Party Signature	Printed Name	Date

Relation to Patient *(if applicable)*: ______________________________

Medications to Hold for Testing

Prescription Antihistamines

- Atarax, Vistaril (hydroxyzine)
- Allegra (fexofenadine)
- Clarinex
- Periactin (cyproheptadine)
- Rondec
- Pediatex
- Pedi-Ox
- Rynnatan
- Q-DAL
- Tussionate
- Tussi-12
- Tannihist
- Xyzal
- *Doxepin/Adapin/Sinequan will need to be held longer than 5 days, but DO NOT STOP it until you have seen the allergist

Over-the-Counter Antihistamines

- Claritin, Alavert, Triaminic, Allerchews, Store Brand Non-Sedating Antihistamine (loratidine)
- Zyrtec (ceterizine)
- Benadryl (diphenhydramine)
- Tavist (clemastine)
- Chlorpheniramine (Like Chlor-Trimeton, Actifed, Allerest)
- NyQuil, Robitussin Night Cold, Tylenol Flu Night Time (doxylamine)
- Tylenol or Advil PM (contain diphenhydramine)
- Dramamine (dimenhydrinate)
- Anything that contains loratadine
- Anything that contains diphenydramine
- Anything that contains brompheniramine
- Anything that contains chlorpheniramine
- Anything that contains carbinoxamine
- Anything that contains doxylamine
- Anything that contains clemastine
- Anything that contains tripolidine
- Anything that contains tripelennamine
- Any “Allergy” or “Cold” Preparation (like Tylenol Cold & Sinus or Advil Cold & Sinus)

Other Types of Medications to Hold 5 Days Before Allergy Testing

Anti-Nausea Medications

- Dramamine (dimehydrinate)
- Doxylamine
- Antivert, Bonine (meclizine)
- Phenergan (promethazine)

Over-the-Counter Sleep Aids

- Any “PM’1 Product (Like Tylenol PM or Excedrin PM or Alka Seltzer PM or Doan’s PM)
- Simply Sleep Nighttime Sleep Aid
- Sominex
- Anything that contains diphenhydramine Nasal and Eye Drops to Hold 48 Hours Before Allergy Testing

Prescription Nasal Sprays

- Astelin Nasal Spray

All Over-the-Counter Eye Drops

- Visine A Eye Drops
- Op-Con A
- Naph-Con A
- Alomide Eye Drops

Prescription Eye Drops

- Patanol Eye Drops
- Zaditor Eye Drops
- Optivar Eye Drops
- Elestat Eye Drops

Medicines That You MAY CONTINUE & Should Not Interfere With Testing

- Saline Nose Spray
- Steroid Nose Sprays
- Afrin Nose Spray
- Singulair
- Asthma Inhalers
- Asthma Nebulizer Treatments
- Nasalcrom
- Crolom
- Zycam
- Mucinex (guaifenesin)
- Cough or Sinus Preparations that only contain dextromethorphan and/or guaifenesin and/or psudoephedrine
- Plain Sudafed (pseudoephedrine)
- “Non-Drowsy” Cold Preparations EXCEPT NO LORATIDINE

AllerVie HEALTH

New Patient Packet

PLEASE DO NOT TAKE ANTIHISTAMINES 5 DAYS PRIOR TO YOUR APPOINTMENT

Patient Information

First Name: ______________________ Last Name: ______________________

Middle Name: ______________________ Suffix: ______________________

Mailing Address: ______________________

City, State, Zip: ______________________

Residential Address (If mailing address is a PO Box): ______________________

City, State, Zip: ______________________

Preferred Phone: ____________ Alternate Phone: ____________ Date of Birth: ____________

Sex: ☐ Male ☐ Female ☐ Other Social Security #: ______________________

Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed Age: ____________

Patient's Employer: ______________________

How did you hear about our practice? ______________________

E-Mail Address: ______________________

Race: ______________________ Ethnicity (check one): ☐ Not Hispanic ☐ Hispanic

Preferred Language: ______________________

Referring Physician's Name: ____________ Telephone #: ____________ Fax #: ____________

Pharmacy Name: ______________________ Pharmacy Phone #: ____________

Responsible Party Information

Name: ______________________ ☐ Spouse ☐ Parent ☐ Guardian's

Mailing Address: ______________________

City, State, Zip: ______________________

Preferred Phone: ____________ Alternate Phone: ____________ Date of Birth: ____________

Social Security #: ______________________

Employer: ______________________

Emergency Information

Contact Name: ______________________ Relationship: ____________

Phone Number: ______________________

Patient Account #: ______________________

AllerVie HEALTH

Medical Insurance Information

Primary Coverage

Company Name: ____________________

Contract (ID) #: ____________________ Group #: ____________________

Name of Policyholder as it appears on card: ____________________ Relationship to Patient: __________

Address of Policyholder: ____________________

Date of Birth: ____________________ RX BIN #: ____________________

Secondary Coverage

Company Name: ____________________

Contract (ID) #: ____________________ Group #: ____________________

Name of Policyholder: ____________________ Relationship to Patient: __________

Address of Policyholder: ____________________

Date of Birth: __________

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of services to be rendered by AllerVie Health to the patient named above, he/she hereby obligates himself/herself, assumes financial responsibility, and agrees to pay upon demand to provider all charges for such services and incidentals incurred by said patient. Should the account be referred to an attorney/collection agency, the undersigned agrees to pay 33% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by the court. The undersigned understands that all bills are payable upon service and that he/she, not the insurance company, is responsible for the payment of all services.

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

I hereby authorize AllerVie Health to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered on above patient.

Signature of Responsible Party: ____________________ Date: ____________________

Printed Name of Responsible Party: ____________________

AllerVie HEALTH

New Patient Packet

ALLERGY HISTORY

1. Name: ______________________________ **Sex:** ____ **Age:** ________________ **Date of visit**: ________________
Referred by / Primary Physician: _______________________________ **Weight:**____________ **Height:**____________

CHIEF COMPLAINT(S): ***Circle the type of problem(s) for which you seek an evaluation***

Nasal allergies, Asthma, Eczema, Chronic cough, Chronic hives, Food allergy, Drug allergy, Reaction to insect sting, Other

NASAL ALLERGY (nose / sinus / eye) symptoms

2. ***How long have you had hay fever symptoms ?_____ yrs / mths***

(CHECK THAT APPLY)	none	mild	Mod	severe
a) Runny nose				
b) Sneezing				
c) Nasal congestion				
d) Post nasal drip				
e) Red, itchy & watery eyes				
f) Itchiness of nose				
of throat				
of palate				
of ears				
g) Sinus headaches				
h) Impaired taste / smell				
i) Post nasal drip cough				
j) Sinus infections				

ASTHMA (chest) symptoms

3. ***How long have you had asthma symptoms ?_____ yrs / mths***

(CHECK THAT APPLY)	none	mild	Mod	Severe
a) Cough +/- Phlegm				
b) Wheezing				
c) Shortness of breath				
d) Chest tightness				
e) Symptoms with exercise				
f) Lump in the throat				
g) Choking, Loss of speech				

SKIN (Eczema / Hives)

4. ***How long have you had skin symptoms? _____***

(CHECK THAT APPLY)	none	mild	mod	Severe
a) Hives (Urticaria)				
b) Swellings (Angioedema)				
c) Eczema / Dry skin				

Answer question #5 if you have asthma symptoms. If not skip to question #6

5. =How often do you have asthma symptoms? Always Daily >2 x per week <2 x per week sporadic Other ______
=Do asthma symptoms wake you up at night? YES / NO if yes, how many times a month / week _______________
=Number of asthma flare visits (specialist or primary care or walk-in clinic) in the past 12 months ________
=Number of Emergency Room visits for asthma flare in the past 12 months ________
=Ever hospitalized for asthma? YES / NO Number of hospitalizations? _____ Last hospitalization _________
=Number of times on oral steroid courses (e.g.; Prednisone, Medrol, Decadron, Steroid shots) in the past 12 months _______
=How many days of work or school have you missed due to asthma in the past 12 months ______________________________
=Do you monitor peak flows at home? YES / NO. If so, what is your ideal peak flow? Morning _______ Evening _______
=Do you have stomach reflux symptoms (sour belching, heartburn, pain or difficulty swallowing) YES / NO

6. Do your symptoms vary with the seasons? YES / NO

If YES, place an "X" in the boxes when symptoms are worse

Symptoms	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Hay fever												
Asthma												
Eczema												
Hives												

7. Are you up to date on routine childhood vaccinations (immunizations)? YES / NO
Flu vaccine received: YES / NO when? ________ Pneumococcal vaccine received: YES / NO when? ________
(Influenza) (Pneumovax 23 and/or Prevnar 13)

List over-the-counter and Prescription drugs used: (include dose and frequency of use)

CURRENT	**PAST**
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

Please continue on to the next page

8. *Check those triggers that cause or worsen your symptoms*

Hay fever	Asthma	Eczema / Hives	Triggers (circle or check all applicable)
			House Dust (Vacuuming, Dusting, Making bed, Shaking bed, Cleaning, sweeping)
			Animals (cats, dogs, hamster, birds, guinea pig, other _________)
			Respiratory infections (Colds, sinus infections, Flu, Bronchitis)
			Exercise
			Night time
			Strong odors (newsprint, fumes), Perfumes, Air refreshners, Cleaners, Hair spray, etc.
			Emotional upset (Stress, Worry), Laughing
			Smoke (Tobacco, Auto exhaust, other ___________)
			Cold air (air conditioning or outside air)
			Weather changes: Rain _____, Cold Fronts _____, Thunderstorm _____, Wind_____
			Smog (Air pollution)
			Drugs (aspirin / Ibuprofen, blood pressure medicine, glaucoma drops)
			Grass mowing, Raking leaves
			Foods / Food additives eg: Sulfites (in dried fruits, wine, beer etc) / other ______
			Menstrual cycle, Pregnancy

9. ***Other allergies*: Food allergy?** YES / NO **Insect Sting reactions** (Bee, YJ, Wasp, Hornets, Fire ants)**?** YES / NO
Drug allergy? YES / NO **Latex rubber allergy?** YES / NO

Have you undergone allergy tests? YES / NO Skin test or Bood test, By whom? ________________________________
Please list the results of your allergy testing ?____
Have you received allergy shots in the past? YES / NO when and how long?__________________________________
Did the allergy shots help your symptoms? YES / NO ____

10. ***Home/Environmental survey*** ***(Fill in the blanks and circle those that apply)***
Years at present address:* ____ *Age of dwelling*: ____ *Dwelling Type: House Apartment Trailer Dorm room Other _______
Trees around the house: Cedar Oak Maple Elm Pecan Pine Other _____ ***Lawn grass**:* Bermuda Fescue Other _____
Visible allergens inside the house: Mold-Mildew Roaches Rodents ***Indoor plants:*** Yes / No
Type of heating: Forced air Gas Radiators Baseboard Wood burning Space heaters Other____________
Type of cooling: Central Window unit fans none ***Humidifier use:*** *(Central / Portable) YES / NO*
Any indoor animals? (Dog, cat, hamster, bird, guinea pig, other ______) ***Outdoor animals?*** (cat, dog, horse, cattle, other______)
Type of bed: Innerspring Foam Waterbed Air mattress Latex Gel Hybrid other ***Comforter***: Feather / Non-feather
Type of pillow: Foam Feather Down Cotton Gel Latex *Water leakage or damage in your home*: Yes / No
Carpets? YES / NO ***Basement present***? YES / NO *If yes, is it Damp*? Yes / No
Latex exposure in the home? Check all that apply (__ Playtex gloves __ Balloons __ Condoms or diaphragm)

11. ***Review of medical problems*** ***(Circle if present)*** Poison ivy/oak dermatitis Chronic snoring Sleep apnea Nasal polyps Heart burn/Reflux Stomach ulcers Diabetes Hypothyroidism/Hyperthyroidism Hepatitis HIV AIDS Weight loss Chronic fever Glaucoma Hypertension Elevated cholesterol Angina Heart failure Kidney stone Chronic bronchitis/Emphysema Bronchiectasis Chronic abdominal pain Chronic diarrhea Colitis Autoimmune disorder Arthritis Migraine Anxiety Depression Anemia Osteoporosis

12. ***Past history of diseases and surgeries***: ***(Circle if present)*** **List surgeries:____**
Asthma Eczema/Atopic dermatitis Chronic hives Hypothyroidism/Hyperthyroidism Nasal Polyps Migraines Recurrent bronchitis Recurrent Pneumonia Recurrent Sinus infections Recurrent ear infections Ear tubes Sinus surgery Tonsils surgery Adenoids surgery Polypectomy Septoplasty

13. ***Family History*** Do any of your family members (parents, siblings, children) have the following conditions?
Nasal allergies Asthma Eczema Drug allergy Food allergy Chronic hives Hereditary Angioedema Colitis Sinus problems Nasal Polyps Cystic Fibrosis Emphysema Autoimmune disorder Migraine Glaucoma Anxiety / depression Immune deficiency Hypertension Diabetes Hypothyroidism/Hyperthyroidism

14. ***Social History***
Marital Status: _______________ ***Current Occupation***: _________________ ***Exposure to chemicals at work**:* YES / NO __________
Hobbies:* ___________________ *Smoking? YES / NO ***Year started smoking? ______ Number of Cigg / day _____***
Quit smoking? Year _______ Does anyone smoke inside your home? YES / NO

History reviewed with the patient in detail YES / NO

Photography & Publicity Release Form

I, the undersigned, do hereby consent and agree that AllerVie Health and its Subsidiaries and Partners, its employees, or agents permission **to use my name, likeness, image, voice, and/or appearance as well as my health information** as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of these entities or their activities.

I agree that AllerVie Health and its Subsidiaries and Partners may use these in any and all media, now or hereafter known, and exclusively for any purpose consistent with their missions. These uses include, but are not limited to illustrations, exhibitions, videos, reprints, reproductions, publications, advertisements, and any promotional, marketing, or educational materials in any medium now known or later developed, including the Internet. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to AllerVie Health and its Subsidiaries and Partners, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial or other remuneration due to me as a result of this agreement or anything described herein.

I also understand that AllerVie Health and its Subsidiaries and Partners are not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, or the legal guardian, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: ____

Address: ____

Phone Number: ______________________

Parent or Legal Guardian: ____________________________________

______________________________ ______________________
Signature Date