Ph. 970.947.0600 | F. 970.947.0601
www.allergyoftherockies.com

Robert McDermott, M.D. *Diplomate - The American Board of Allergy and Immunology*
Regan Pyle, D.O. *Diplomate - The American Board of Allergy and Immunology*
Laura Bond, PA-C | Amy Johnson, PA-C | Lindsey Kramer, FNP

Dear Patient:

Welcome to Allergy, Asthma, and Immunology of the Rockies, P.C. Thank you for trusting us with your medical care. We are committed to providing you with personalized and compassionate care using the most current practices in allergy and immunology. We look forward to helping you feel your best!

We would like to provide some helpful resources for you as you continue care with us.

OUR TEAM:

- We have over 30 years of combined experience
- Dr. Robert McDermott, Board-certified Allergy and Immunology
- Dr. Regan Pyle, Board-certified Allergy and Immunology
- Laura Bond, PA-C, Amy Johnson, PA-C, Lindsey Kraemer, FNP

APPOINTMENTS:
We are available from 8 a.m. to 5 p.m. Monday through Friday and offer in office and telehealth appointments at our Glenwood Springs, Avon, Basalt and Frisco locations. There are 2 options to make an appointment:
By phone: 970-947-0600 (option 1)
Online: https://www.allergyoftherockies.com (request only)

QUESTIONS ABOUT YOUR VISIT?
Call 970-947-0600
-option 1: front desk
-option 2: nurses line

RESOURCES ABOUT CONDITIONS WE TREAT
https://www.allergyoftherockies.com/services

REFILL REQUESTS:
For prescription refills, please contact your pharmacy and they will send us a request for a refill.

It is an honor and a privilege that you have chosen us to help you with your allergy and immunology needs. Please feel free to reach out of us with any questions or concerns. We are here for you!

Sincerely,

Robert McDermott, MD, Regan Pyle, DO and AAIR Staff

Allergy, Asthma & Immunology of the Rockies, P.C.

AllerVie HEALTH

Patient Registration Form

Patient Name (Last, First, Middle Initial)	**Patient Date of Birth**	**Patient SSN**
Patient Mailing Address	**City/State/Zip Code**	**Marital Status**
Preferred telephone number	**Secondary telephone number**	**Email Address** *(for appointment reminders)*
Primary Care Physician's Name*	**Practice's Name**	**PCP's Phone Number**
Primary Care Physician's Address	**City/State**	**Zip Code**
Specialist Physician's Name*	**Practice's Name**	**Specialist's Phone Number**
Specialist's Address	**City/State**	**Zip Code**
How did you hear about us: __Primary Care Physician Referral __ Specialist __ Yellow Pages __Internet __Advertisement __ Family __Insurance __ Friend __Newspaper __ Other		
*** I authorize AAIR, P.C. to send a written report to my above Doctors: __Yes __NO**		
*** I authorize AAIR, P.C. to contact me via E-mail and or Text message __Yes __NO**		

***For the below information, *if the patient is a child*, please fill out the parent/legal guardian's information. ***
****If the patient is an adult*, please fill out the following employment information *for the patient and spouse* if applicable. ***

Name DOB SSN	**Name DOB SSN**
Mailing Address	**Mailing Address**
City/State/Zip Home Phone #	**City/State/Zip Home Phone #**
Employer Name Work Phone #	**Employer Name Work Phone #**
Employer Address	**Employer Address**
City/State/Zip	**City/State/Zip**

Emergency Contact Name
Relationship
Home Phone Number

Primary Insurance	**Secondary Insurance**
Insurance Name	**Insurance Name**
Policy/Subscriber Number Group Number	**Policy/Subscriber Number Group Number**
Subscriber Name/DOB/SSN	**Subscriber Name/DOB/SSN**

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Robert McDermott, MD when he accepts assignment.

Patient Signature/Legal Guardian:_____ **Date:**_____
Witness Signature:_____ **Date:**_____

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350 Market St., Suite 200, Basalt, CO 81621 | 50 Buck Creek Rd., Suite 105, Avon, CO 81620

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing Allergy, Asthma & Immunology of the Rockies, P.C. of your wish to designate the named person as your personal representative. Your personal representative will be treated as the subject of your protected health information and shall have the right to act on behalf in making health care decisions.

You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to the front office receptionist.

DESIGNATION SECTION

I_____ *(print)* hereby nominate _____ *(print)* to act as my personal representative with respect to decision involving the use and/or disclosure of health information that pertains to me.

This person is to be afforded all privileges that would be afforded to me with respect to my health information when acting as my personal representative.

I understand that I may revoke this designation at any time by signing the revocation section of this form and returning it to the front office. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____
Patient Signature Date

REVOCATION SIGNATURE

I hereby revoke this designation of a personal representative.

_____ _____
Patient Signature Date

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Private Policy HIPAA Acknowledgement

I, _____ (patient), acknowledge that I have received a copy of Allergy Asthma & Immunology of the Rockies, P.C. Notice Regarding Privacy of Personal Health Information.

_____ _____
Date Patient/Guardian Signature

_____
Relationship to patient if not patient

Allergy, Asthma & Immunology of the Rockies, P.C.

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Financial Policy

Welcome to Allergy, Asthma, & Immunology of the Rockies. It is important that all our Policies are fully understood by you to ensure you receive continuous, experienced and timely health care. Please read this policy and acknowledge your understanding and agreement with your signature. We invite you to ask questions and/or clarifications if you have any. Thank you.

I agree that:
AAIR, PC. will bill my insurance, provided all the necessary information is given to the clinic at the time of service. This includes a valid, current insurance card. If this is not available, I will be asked to pay all charges for the date's visit before I leave the office. AAIR, PC will ask to see your insurance card at every visit to ensure that we have all the proper billing data and that the card is current.

If my insurance company does not submit payment within 30 days, I understand I will be responsible for any and all outstanding balances. I am aware that my insurance carrier, rather than my physician, may deny some services for the reason of "not medically necessary" or "non-covered services, therefore, I will become fully responsible for payment of these services.

If I have asked for an estimate of cost for my visit, this will be given as closely as possible. However, since AAIR, PC is not aware of the exact number of skin tests, level of care etc. that will be needed until the physician has seen the patient; this is considered only as an estimate and not an exact charge quote.

I assume all responsibility for the deductible costs of my insurance plan. These costs will be billed to me immediately by AAIR, PC when my insurance plan states that these are my costs and not theirs.

AAIR, PC will make all attempts to collect payment from the insurance carrier; however, I am ultimately responsible for all costs associated with my visit. Though insurance coverage may be carried, it is not a guarantee of payment. I understand that if my insurance company fails to pay AAIR, PC, any remaining balance will be my financial responsibility and will be paid in full upon receiving a statement of balance. I will pay this balance within 15 days or contact AAIR, PC to make financial arrangements. I agree to allow AAIR, PC to telephone me at any of my phone numbers given to AAIR, PC to discuss any issues regarding payment of my account. A late fee of $20.00 will be assessed if my account is not paid in 45 days. All bills must be paid in full within 57 days or my account may be sent to an outside collection agency. Once this is done, I must deal directly with the collection agency and not AAIR, PC as it is out of their hands to do anything with my account. This agency will add the appropriate fees for collection if my account is sent there. At this time AAIR, PC will cease giving care to me and my dependents.

_____

Signature of Patient (or Legal Guardian) Date

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Cancellation of Appointments

Our goal at AAIR, PC is to provide high quality medical care in a timely manner. In order to do so, we have had to establish an appointment cancellation policy. This policy will enable us to better utilize available appointments for our patients in need of medical care.

A scheduled appointment means that time is reserved only for you. We ask that you call at least **48** hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient in need of timely medical care. Failure to give **48** hours notice prior to cancellation may result in a "No-show" appointment fee of $25. This fee cannot be billed to your insurance company and will be your direct responsibility.

To cancel, please call 970-947-0600 and dial 0 to speak to the front desk. Before or after regular business hours, please leave a message with your name, appointment time, reason for canceling and a phone number for us to reach you to reschedule.

Thank you for your understanding in this matter.

_____

Signature of Patient (or Legal Guardian) Date

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Consent for Testing and Authorization of Treatment of a Minor (Patients under 18 years of age)

I do hereby give authorization and consent for the patient designated below to be evaluated and, when indicated, treated by Robert McDermott, MD and his staff without the presence of a parent or guardian. In addition, I give authorization and consent for treatment of any reactions that may occur as a result of testing without the presence of a parent or guardian.

_____	_____
Printed Name of Patient	Medical Record Number
_____	_____
Parent/Legal Guardian Signature	Date
_____	_____
Family Representative Signature	Date
_____	_____
Witness	Date

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PATIENT INTAKE QUESTIONNAIRE

PATIENT NAME _____**DATE OF BIRTH**_____

WHAT BRINGS YOU IN TODAY? _____
_____
WERE YOU REFERRED, AND IF SO BY WHOM? _____
_____
HAVE YOU EVER BEEN EXPOSED TO TUBERCULOSIS OR HAD A POSITIVE TB SKIN TEST? **YES** **NO**

Here for environmental allergies?: (IF NO, CIRCLE **NO,** AND MOVE ON TO NEXT SECTION**)** **NO**

- SNEEZING
- RUNNY NOSE
- NASAL CONGESTION BOTH SIDES? _____
- POST NASAL DRIP
- BLOODY NOSE
- SENSE OF SMELL IMPAIRED
- SENSE OF TASTE IMPAIRED
- EYES: ITCHY WATERY RED SWOLLEN EYELIDS IMPAIRED VISION COLORED DISCHARGE
- IMPAIRMENT OF WORK OR SCHOOL?
- TRIGGERS:
  - SEASONS: SPRINGSUMMER FALL WINTER YEAR ROUND
  - ANIMALS
  - WORKING OR PLAYING OUTDOORS
  - STRONG ODORS/PERFUMES
  - DUST EXPOSURE
  - TEMPERATURE CHANGES
  - ASPIRIN INGESTION
- HISTORY OF NASAL POLYPS
- HISTORY OF DEVIATED SEPTUM
- HISTORY OF SEPTAL PERFORATION
- HISTORY OF RECURRENT SINUS INFECTIONS?
  - IF YES HOW MANY PER YEAR?_____
  - RECENT COLORED NASAL DISCHARGE?_____COLOR_____
  - FACIAL PAIN, HEADACHES?_____
  - HISTORY OF SINUS SURGERY?_____
  - SINUS CT?_____WHEN/WHERE?_____
- NEED FOR ORAL STEROIDS? (Eg. ORAPRED, PREDNISONE TABLETS OR SYRUP, MEDROL, STEROID INJECTIONS) How many times in the last year_____
- NASAL OBSTRUCTION
- SNORING
- DISRUPTED OR UNRESTFUL SLEEP
- DAYTIME SLEEPINESS OR NAPS

- OCCASIONALLY STOP BREATHING WITH EXCESSIVE SNORING
- PREVIOUS MEDICATIONS:
    - NASAL STEROIDS EFFECTIVE/NOT EFFECTIVE
    - ANTIHISTAMINES EFFECTIVE/NOT EFFECTIVE
    - SINGULAIR EFFECTIVE/NOT EFFECTIVE

PATIENT NAME:_____

CHEST AND LOWER RESPIRATORY SYMPTOMS

- HISORY OF ASTHMA AGE DIAGNOSED? _____
- WHEEZING
    - WHILE BREATHING OUT? IN? BOTH?
    - >2 TIMES PER WEEK AT REST DURING THE DAY
    - DAILY SYMPTOMS AT REST
    - NIGHTTIME SYMPTOMS >2 TIMES PER MONTH
    - EXERCISE INDUCED WHEEZE OR COUGH
- EPISODES OF TURNING BLUE
- HOSPITALIZED FOR ASTHMA: LOCATION?_____WHEN?_____
- INTENSIVE CARE UNIT OR RESPIRATOR REQUIRED
- EMERGENCY DEPARTMENT FOR ASTHMA: LOCATION?_____WHEN?_____
- FREQUENCY OF ALBUTEROL OR RESCUE INHALER USE?_____
- NEED FOR ORAL STEROIDS? (Eg. ORAPRED, PREDNISONE TABLETS OR SYRUP, MEDROL, STEROID INJECTIONS)
    - How many times in the last year_____
- MISSED SCHOOL OR WORK

- COUGH
    - BRINGS UP SPUTUM, AND IF SO, COLOR?_____
    - DRY NONPRODUCTIVE
    - DISRUPTS SLEEP OR WORSE AT NIGHT
    - BLOOD IN SPUTUM
    - HISTORY OF TB (TUBERCULOSIS) EXPOSURE
- ACID REFLUX SYMPTOMS

- TRIGGERS OF YOUR SYMPTOMS:
    - SEASONS: SPRINGSUMMER FALL WINTER YEAR ROUND
    - ANIMALS
    - WORKING OR PLAYING OUTDOORS
    - STRONG ODORS/PERFUMES
    - DUST EXPOSURE
    - TEMPERATURE CHANGES
    - ASPIRIN INGESTION
    - EXERCISE
    - TOBACCO SMOKE EXPOSURE
- MEDICATIONS FOR ASTHMA?
    - ALBUTEROL/XOPENEX?
        - FREQUENCY OF USE_____

OTHER MEDICATIONS?:
_____
_____
_____
_____

PATIENT NAME:_____

PAST MEDICAL AND ALLERGIC HISTORY
CHRONIC AND PAST MEDICAL PROBLEMS (PLEASE LIST PRIOR MEDICAL PROBLEMS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE BEEN TREATED FOR IN THE PAST):

_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS:

_____
_____
_____
_____
_____
_____

ER VISITS:

_____
_____
_____
_____
_____
_____

PAST SURGERIES:

_____
_____
_____
_____
_____
_____

FOOD ALLERGIES:

_____
_____
_____
_____
_____
_____

LATEX ALLERGIES:
___YES_____
___NO_____
____

INSECT ALLERGIES:
___YES_____NO____
TYPE OF INSECT_____
LOCAL REACTION ONLY?_____
OTHER REACTION_____

IMMUNIZATIONS UP TO DATE: YES NO
LAST FLU VACCINE_____

LAST PNEUMONIA VACCINE_____

MEDICATIONS (PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING):

_____
_____
_____
_____
_____
_____

BETA BLOCKER OR ACE INHIBITOR FOR HIGH BLOOD PRESSURE? _____

DRUG ALLERGIES OR ADVERSE REACTIONS(PLEASE LIST ANY MEDICATIONS YOU HAVE AN ALLERGY TO OR HAVE REACTED TO ADVERSLY AND WHAT YOUR REACTION WAS):

_____
_____

PATIENT NAME:_____

ENVIRONMENTAL AND SOCIAL:
HOME LIVING ENVIRNMENT:

MOLD OR WATER DAMAGE: YES NO

BEDDING: PILLOW FEATHER NON FEATHER COMFORTER: FEATHER NON FEATHER

PETS: DOG (s) _____ CAT(s)_____BIRD(s)_____ OTHER:

BEDROOM PETS: _____

PREV. PETS_____

SMOKE EXPOSURE: SECONDARY TOBACCO OR MARAJUANA SMOKE EXPOSURE: YES NO

SMOKING: CURRENT? Yes/No Packs per day if yes? _____ Number of Years_____ PAST SMOKING HISTORY? _____

OCCUPATION: _____

DRUG/ALCOHOL USE_____

HOBBIES: _____

FAMILY HISTORY:

PARENTS:
ASTHMA: _____
ALLERGIES: _____
OTHER: _____

SIBLINGS:
ASTHMA: _____
ALLERGIES: _____
OTHER: _____

OTHER:

HISTORY OF CYSTIC FIBROSIS OR OTHER LUNG DISORDERS? _____

PATIENT NAME:_____

REVIEW OF SYSTEMS

General/Constitutional □yes □no
□ Weight loss or gain, ____lbs □Fevers □Night sweats □decreased energy

Skin: □yes □no
□Rash □itching □dryness □changes in hair growth or loss□nail changes
□ Unusual appearing or large moles

Eyes: □yes □no □as previously discussed
□Cataracts □Glaucoma □Loss of vision □blurred vision □Eye pain

Ears/Nose/Mouth/Throat □yes □no □as previously discussed
□Headaches (location, time of onset, duration, precipitating factors), vertigo, lightheadedness, injury
□Nose bleeding
□Dental difficulties, gum bleeding, dentures
□Neck stiffness, pain, tenderness, masses in thyroid or other areas
□Difficulty swallowing □painful swallowing

Cardiovascular □yes □no
□Chest pain □Heart palpitations □Left arm pain, numbness □Murmur □difficulty breathing while lying flat □lower extremity swelling

Respiratory □yes □no □as previously discussed
□Shortness of breath, wheezing, stridor, cough □respiratory infections, tuberculosis (or exposure to tuberculosis)

Gastrointestinal □yes □no
□Abdominal pain □heartburn □nausea □vomiting □constipation □diarrhea
□abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling)

Genito-urinary □yes □no
□Increased frequency □urgency □blood in urine □prostate problems
□kidney problems

Musculo-skeletal □yes □no
□Pain □swelling in joints hands or legs □redness or heat of muscles or joints
□limitation of motion □muscular weakness □muscle cramps

Neurologic/Psychiatric □yes □no
□Convulsions or seizures □Depression □Anxiety □Hyperactivity □ADHD
□Dizziness or passing out

Endocrine □yes □no
□Thyroid disorder □heat intolerance □cold intolerance □excessive thirst/hunger

Blood/Lymphatic □yes □no
□Swollen lymph nodes or "glands" □Easily bruise □Bloody gums or bleed easily □history of lymphoma
□HIV testing □positive □negative □Blood transfusion

Are you pregnant or planning pregnancy? □yes □no