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:

- If you are coming for an allergy consultation or an allergy test, please discontinue all antihistamines FIVE days before your appointment. Common medications containing antihistamines are Benadryl, Triaminic, cough, and cold medicines. Do not stop taking Singulair or asthma inhalers. If you have questions about medications, you can find a complete list of medications to hold at allervie.com/patient-resources.
- 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.

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.

Patient Name_____ DOB_____

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, its Subsidiaries, and Partners for the purpose of diagnosing and providing treatment, obtaining payment, or conducting healthcare operations of AllerVie Health. I understand that diagnosis or treatment 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 AllerVie Health or Healthcare Providers of AllerVie Health have taken action in reliance on this consent prior to my withdrawal.

"Protected Health Information" means health information, including demographic information, collected, 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 past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may be able to be used to identify me.

The Notice of Privacy Practices for AllerVie Health has been provided via electronic access and can be provided in paper format, upon request. I understand I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur to ensure treatment, insurance collection, and performance of collaborative 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 online on AllerVie's main website or by 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

Whether signing as an agent or as a patient, the undersigned agrees that in consideration of agreed upon services to be rendered by AllerVie Health to the patient, including allergy extracts and injections, the patient and representatives hereby obligates themselves, assuming financial responsibility, and agreeing to AllerVie Health's payment policy as outlined below regarding all charges for such services incurred by the patient. The undersigned consents to treatment as determined and discussed with their AllerVie provider and agrees to provide accurate medical histories and participate in health assessment and treatment. The undersigned also specifically agrees that AllerVie Health can use PHI to communicate via phone, email, or text for essential follow up needs, appointment reminders, care coordination, as well as conduct analysis for internal business purposes, customize patient needs for services, and create de-identified information to use and disclose in any way 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.

Patient Name_____ DOB_____

Patient Financial Consent Policy

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

Thank you for choosing AllerVie Health. To ensure clarity about your financial responsibilities, please review & initial each policy:

Proof of Insurance: _____ *Initials*
- Provide updated insurance information and photo ID at every visit.
- Incorrect or expired insurance information may result in patient responsibility for charges.
- Inform us of insurance changes before your appointment.
- Unverified or denied insurance coverage will be your responsibility.

Insurance Coverage: _____ *Initials*
- AllerVie Health will file claims with participating insurers as a courtesy.
- You must pay copayments, deductibles, and coinsurance at the time of service.
- Understanding your insurance benefits is your responsibility.
- You must pay charges not covered by your insurance.

Copayments, Deductibles, and Coinsurance: _____ *Initials*
- Payment of copayments, deductibles, and coinsurance is required at each visit per your insurance agreement.
- Promptly provide additional information requested by your insurer.

Referrals: _____ *Initials*
- If your insurance plan requires a referral to see an allergist or a referral authorization number, you must ensure this referral is received by our office at least 24 hours prior to your appointment, or your appointment may be rescheduled.

Self-Pay: _____ *Initials*
- Self-pay patients must make payment at the time of service.

No-Show Appointments: _____ *Initials*
- Cancel appointments at least 24 hours in advance to avoid a $50 no-show fee.
- Appointments not canceled within this timeframe will incur a $50 fee, which will be charged directly to your account.

Failure to Pay: _____ *Initials*
- Past-due accounts may result in suspended non-urgent care, dismissal from the practice, or referral to collections.
- Unpaid debts may be reported to credit bureaus.

Card on File: _____ *Initials*
- We encourage patients to keep a credit card securely on file to facilitate payment.
- Card information will only be used for authorized healthcare-related charges.
- Authorization remains effective until revoked in writing.

Signature and Acceptance

I understand that payment for all charges is my responsibility, regardless of insurance coverage. By signing or electronically agreeing, I legally acknowledge and accept these terms.

_____ _____ _____

Patient or Legal Guardian/Responsible Party Signature | Printed Name | Date

Relation to Patient *(if applicable)*: _____

Patient Name_____ DOB_____

Medications to Stop for Testing

Prescription Antihistamines

- Atarax, Vistaril (hydroxyzine)
- Allegra (fexofenadine)
- Clarinex
- Periactin (cyproheptadine)
- Rondec
- Pediatex
- Pedi-Ox
- Rynnatan
- Q-DAL
- Tussionate
- Tussi-12
- Tannihist
- Xyzal
- Anything that contains levocabastine
- *Doxepin/Adapin/Sinequan will need to be held longer than 5 days, but DO NOT STOP it until you have discussed these medications with your 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)
- Pepcid/Zantac (famotidine)
- Dramamine (dimenhydrinate)
- Anything that contains loratadine
- Anything that contains famotidine
- 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)

This list is not comprehensive of all medications. For any questions please contact the office prior to your visit.

Other Types of Medications to Stop 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

Prescription Nasal Sprays

- Astelin/azelastine
- Patanase/olopatadine

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
- Olopatadine/Azelastine 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

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 #: _____

Patient Name _____ DOB _____

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 the 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 the maximum lawful fee, at such time the 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: _____

Patient Name _____ DOB _____

Medical History

1. Reason for visit: _____

Primary Care Physician: _____ ☐ I would like my results shared with this Physician

2. Medications - Please bring a full list to your appointment or complete the box below.

Name	Dose	Directions	Frequency

3. Local Pharmacy

Name: _____

Address: _____

Phone: _____

3. Mail Order Pharmacy

Name: _____

Address: _____

Phone: _____

4. Please list all drug allergies. Include the drug name and type of reaction.

Drug Name	Type of Reaction

Allergy History

1. Have you ever had:

☐ Hay Fever/Seasonal Allergies ☐ Childhood Asthma ☐ Adult Onset Asthma

☐ Eczema ☐ Hives ☐ Allergic Eyes ☐ Insect Sting Reaction

☐ Food Allergies ☐ Swelling ☐ Latex Allergy ☐ Chemical Allergy

2. List all food allergies and describe the reaction and dates(s):

_____

_____

_____

Patient Name _____ DOB _____

3. Have you ever been tested for allergies? ☐ Yes ☐ No When? _____

If yes, what type of testing did you have? ☐ Skin tests ☐ Blood tests ☐ Other, Describe: _____

What healthcare provider performed your allergy testing? Name/Practice: _____

What were the test results? _____

4. Have you ever had allergy immunotherapy (shots or oral)? ☐ Yes ☐ No

If yes, did they help? ☐ Yes ☐ No

If yes, please give provider name and year: _____

How long did you receive your allergy immunotherapy (shots or oral) from this provider? _____

5. Have you ever had other allergic reactions to:

☐ Foods, Describe: _____

☐ Medications, Describe: _____

☐ Latex

☐ Insect Stings

What insect? ☐ Honey Bee ☐ Yellow Jacket ☐ Wasp ☐ Hornet

☐ Fire Ant ☐ Other: _____

If yes, was reaction: ☐ local, generalized hives and/or swelling or ☐ anaphylaxis

6. How many sinus infections per year do you get? ☐ 1 ☐ 2-3 ☐ 3-4 ☐ 5 or greater ☐ None

7. How many lung infections per year do you get? ☐ 1 ☐ 2-3 ☐ 3-4 ☐ 5 or greater ☐ None

8. How many courses of antibiotics per year do you get? ☐ 1 ☐ 2-3 ☐ 3-4 ☐ 5 or greater ☐ None

9. How many steroid courses per year do you get? ☐ 1 ☐ 2-3 ☐ 3-4 ☐ 5 or greater ☐ None

10. How many symptom-free days have you had in the last 2 weeks?

☐ 1 ☐ 2-3 ☐ 3-4 ☐ 5 or greater ☐ None

11. How many Emergency Room visits have you had in the last 6 months?

☐ 1 ☐ 2-3 ☐ 3-4 ☐ 5 or greater ☐ None

Dates of ER visits: _____

12. How many hospitalizations have you had in the last 12 months?

☐ 1 ☐ 2-3 ☐ 3-4 ☐ 5 or greater ☐ None

Dates of Hospitalizations: _____

Patient Name _____ DOB _____

Social History

1. Smoking Status: (please check) ☐ Never Smoked ☐ Current smoker: How often? _____
   ☐ Previous smoker: Year that you quit? _____

2. Current Occupation: _____
   If a child, please indicate: ☐ Student-What Grade? ☐ Daycare/Preschool ☐ Not Applicable

3. Do your hobbies involve any of the following? ☐ Chemicals ☐ Particulates ☐ Animals ☐ Outdoor Sports

4. How many times in the past year have you had 4 or more drinks in a day?

5. Select which vaccines you are up to date on, if any:
   ☐ Influenza (19+, within last 12 months) ☐ Tetanus (19+, within last 9 years)
   ☐ Pneumococcal (66+) ☐ Herpes Zoster (50+)

Environmental History

1. Do you live in a (check all that apply):
   ☐ House ☐ Apartment ☐ Condo ☐ Duplex ☐ Assisted Living ☐ Nursing Home
   ☐ Townhouse ☐ Dormitory ☐ Shelter ☐ Homeless

2. What type of heating is in your residence (check all that apply):
   ☐ Electric ☐ Gas ☐ Coal ☐ Oil ☐ Solar ☐ Wood-Burning ☐ Window-Unit
   ☐ Other, Describe: _____

3. What type of cooling is in your residence (check all that apply):
   ☐ Central electric ☐ Central gas ☐ Window-Unit ☐ Fans
   ☐ Other, Describe: _____

4. What type of mattress do you use?
   ☐ Spring ☐ Foam ☐ Waterbed ☐ Air ☐ Latex gel ☐ Other, Describe _____

5. What type of pillow do you use?
   ☐ Cotton ☐ Feather/Down ☐ Foam ☐ Gel ☐ Other, Describe: _____

6. What type of flooring is in your residence:
   ☐ Carpet ☐ Wood ☐ Tile ☐ Vinyl ☐ Other, Describe: _____

7. Have you noted any water leaks in your residence: ☐ past ☐ current ☐ unknown ☐ none

8. Do you have any visible Allergens in your residence: ☐ Mold ☐ Mildew ☐ Roaches ☐ Rodents

9. Describe the type of grass around your residence: _____

10. Describe the type of trees around your residence: _____

11. Do you have any exposure to latex:
☐ Balloons ☐ Condoms ☐ Diaphragm ☐ Gloves ☐ Body tape ☐ None
☐ Other, Describe _____

12. Do you have pets? ☐ None
☐ Dogs If yes: ☐ 1-2 ☐ 2 + ☐ Inside ☐ Outside
☐ Cats If yes: ☐ 1-2 ☐ 2 + ☐ Inside ☐ Outside
☐ Other: _____

13. Do you have anyone that smokes living in your household? ☐ None ☐ Yes

For Children Under 15, Complete the Following

1. Birth Weight:_____

2. Were there any complications following delivery? ☐ Yes ☐ No
If yes, was there an intensive care unit stay? ☐ Yes ☐ No

3. Were there any severe respiratory infections under age 8? ☐ Yes ☐ No
Please specify: ☐ RSV ☐ Pneumonia ☐ Severe bronchitis ☐ Croup

4. Has growth and development been normal? ☐ Yes ☐ No
If no, explain: _____

5. Are immunizations up to date? ☐ Yes ☐ No

Preventive Measures

1. Have you received any of the following vaccines within the last 12 months?
☐ Pneumonia Vaccine
☐ RSV
☐ Shingles
☐ COVID

2. If you are age 40 or above, have you ever received the pneumonia vaccine? ☐ Yes ☐ No
If yes, _____

Patient Name_____ DOB_____

Asthma Control Test

If you are being seen for asthma or asthma symptoms, please circle the best answer to the following questions below:

(For Age 12 years or older)

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home?
   ☐ (1) All of the time ☐ (2) Most of the time ☐ (3) Some of the time ☐ (4) A little of the time ☐ (5) None of the time

2. In the past 4 weeks how often have you had shortness of breath?
   ☐ (1) More than once a day ☐ (2) Once a day ☐ (3) Three to six times a week ☐ (4) Once or twice a week ☐ (5) Not at all

3. In the past 4 weeks how often did your asthma symptoms wake you up at night or earlier than usual in the morning?
   ☐ (1) 4 or more nights a week ☐ (2) 2 or 3 nights a week ☐ (3) Once a week ☐ (4) Once or twice ☐ (5) Not at all

4. In the past 4 weeks how often have you used your rescue inhaler or nebulizer medication?
   ☐ (1) 3 or more times per day ☐ (2) 1 or 2 times a day ☐ (3) 2 or 3 times a week ☐ (4) Once a week or less ☐ (5) Not at all

5. How would you rate your asthma control in the past 4 weeks?
   ☐ (1) Not controlled at all ☐ (2) Poorly controlled ☐ (3) Somewhat controlled ☐ (4) Well controlled
   ☐ (5) Completely controlled

Total Score: _____

(For Ages 4 to 11 years)

1. (To the child) How is your asthma today?
   ☐ (0) Very Bad ☐ (1) Bad ☐ (2) Good ☐ (3) Very Good

2. (To the child) How much of a problem is your asthma when you run, exercise, or play sports?
   ☐ (0) It's a big problem, can't do what I want ☐ (1) It's a problem ☐ (2) It's a little problem, but okay ☐ (3) It is not a problem

3. (To the child) Do you cough because of your asthma?
   ☐ (O)Yes, all of the time ☐ (1)Yes, most of the time ☐ (2)Yes, sometimes ☐ (3) No, none of the time

4. (To the child) Do you wake up at night because of your asthma?
   ☐ (O)Yes, all of the time ☐ (1)Yes, most of the time ☐ (2)Yes, sometimes ☐ (3)No, none of the time

5. (To the parent) During the past 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?
   ☐ (0) Everyday ☐ (1) 19-24 days/month ☐ (2) 11-18 days/month ☐ (3) 4-10 days/month ☐ (4) 1-3 days/ month ☐ (5) Not at all

6. (To the parent) During the past 4 weeks how many days per month did your child wheeze during the day due to asthma?
   ☐ (0) Everyday ☐ (1) 19-24 days/month ☐ (2) 11-18 days/month ☐ (3) 4-10 days/month ☐ (4) 1-3 days/month ☐ (5) Not at all

7. (To the parent) During the last 4 weeks how many days per month did you child wake up during the night due to asthma?
   ☐ (0) Everyday ☐ (1) 19-24 days/month ☐ (2) 11-18 days/month ☐ (3) 4-10 days/month ☐ (4) 1-3 days/month ☐ (5) Not at all

Total Score: _____

Patient Name_____ DOB_____

Medical History – Please check off any applicable conditions

Condition	When	Explain
☐ Acid Reflux/GERD/Heartburn		
☐ Acute ear infections		
☐ Allergic Rhinitis		
☐ Allergies		
☐ Anemia		
☐ Anxiety		
☐ Arthritis		
☐ Asthma		
☐ Atopic Dermatitis		
☐ Bronchiolitis		
☐ Bronchitis - Acute, Chronic		
☐ Cancer		
☐ Cardiovascular disease		
☐ Chronic Bronchitis/COPD/Emphysema		
☐ Chronic Diarrhea		
☐ Chronic ear infections		
☐ Chronic Fever		
☐ Colitis		
☐ Contact Dermatitis		
☐ Cough		
☐ Depression		
☐ Deviated Nasal Septum		
☐ Diabetes		
☐ Difficulty Swallowing		
☐ Eczema		
☐ Gallbladder disease		
☐ Glaucoma		
☐ Headache		
☐ HIV/AIDS		
☐ Hypercholesterolemia		
☐ Hypertension		
☐ Kidney Problems		
☐ Liver Disease		
☐ Nasal Fracture		
☐ Osteoporosis		
☐ Peptic Ulcer Disease/Stomach Ulcers		
☐ Pleurisy		
☐ Pneumonia		
☐ Rash		
☐ Seizure Disorder		
☐ Sinusitis		
☐ Sleep Apnea/Chronic Snoring		
☐ Thyroid Disease		
☐ Tonsillitis		
☐ Trouble Breathing		
☐ Tuberculosis		
☐ Urticaria/Hives		

Patient Name_____ DOB_____

Surgical History – Please check off any procedure or surgeries

Surgical Procedure	When	Explain
☐ Adenoidectomy		
☐ Angioplasty/Stents		
☐ Appendectomy		
☐ Back Surgery		
☐ Biopsy (please specify)		
☐ Blood Transfusion		
☐ Bronchoscopy		
☐ CABG		
☐ Carpal Tunnel Release		
☐ Cataract Surgery		
☐ Cesarean Section		
☐ Cholecystectomy		
☐ D&C		
☐ Endoscopy - GI		
☐ Gastric Bypass		
☐ Hernia Repair		
☐ Hip Surgery		
☐ Hysterectomy		
☐ Knee Surgery		
☐ Myringotomy/Ear Tubes		
☐ Nasal Polypectomy		
☐ Nasal Septoplasty		
☐ Sinus Surgery		
☐ Thoracotomy		
☐ Thyroidectomy		
☐ Tonsillectomy		
☐ Vasectomy		
☐ Wisdom Teeth/Tooth Abstraction		

Family History – Indicate which relative has had the following diseases:

Disease	Father	Mother	Brother	Sister	Son	Daughter	Other	No
Allergic Rhinitis								
Asthma								
Autoimmune Disorder								
Chronic Hives								
Colitis								
Cystic Fibrosis								
Diabetes								
Drug Allergy								
Eczema								
Eczema/Atopic Dermatitis								
Food Allergy								
Glaucoma								
Hereditary Angioedema								
Hypertension								
Hyperthyroidism								
Hypothyroidism								
Immunodeficiency								
Migraine								
Other:								

AllerVie HEALTH

Patient Name _____ DOB _____

Review of Systems

Are you currently experiencing any of the following:

General	Yes	No
Fever		
Chills or night sweats		
Weight loss		
Weight gain		
Tired/Weakness/Fatigue		

Skin/Hair	Yes	No
Rash		
Hives		
Itchiness		
Eczema		

Eyes	Yes	No
Worsening eyesight		
Cataracts		
Glaucoma		
Pain		
Infection		

Ears, Nose & Throat	Yes	No
Dizziness		
Loss of hearing		
Earache		
Ringing in ears		
Nose bleeds		
Sore throat		
Hoarseness		
Mouth sores		
Thrush		
Pain in neck		

Lungs	Yes	No
Cough up blood		
Pneumonia		
Shortness of breath		
Chronic bronchitis		

Heart/Blood Vessels	Yes	No
High blood pressure		
Pain/tightness in chest at rest or exercise		
Heart murmur		
Heart Palpitations		
Pace maker		

Gastrointestinal	Yes	No
Heartburn		
Nausea		
Vomiting		
Stomach pain		
Diarrhea		
Constipation		
Hemorrhoids		
Bloody stools		
Recent loss of appetite		
Jaundice		
Hepatitis		
Ulcer		

Endocrine	Yes	No
Goiter/Thyroid problems		
Diabetes mellitus		
Frequent thirst		
Frequent urination		
Heat intolerance		
Cold intolerance		

Musculoskeletal	Yes	No
Joint pain		
Arthritis		
Muscle aches/weakness		
Ulcers on legs or feet		

Genitourinary	Yes	No
Frequent urination		
Urine infections		
Pain/burning on urination		
Difficulty with urination		
Blood in urine		
Kidney stones		

Neurological	Yes	No
Seizures		
Tingling		
Numbness		
Poor balance		
Stroke/paralysis		
Difficulty with speech		
Tremors		
Headaches		

Psychiatric	Yes	No
Anxiety		
Memory loss		
Panic disorder		
Bipolar		
Schizophrenia		

Hematology	Yes	No
Anemia or low blood		
Bruise easily		
Swollen glands		
Blood clots		
Blood transfusions		

Women Only	Yes	No
Menstrual problems		
STD		

Men Only	Yes	No
Prostate trouble		
STD		
Discharge from penis		
Pain or lump in testicles or scrotum (sac)		

I acknowledge that all information regarding my medical history is correct and accurate to my knowledge. By signing this document I understand that I am held accountable for any false information which could impede proper treatment provided by the healthcare providers and staff of the AllerVie Health. I am aware that I am responsible for providing updated information to the physicians and staff of AllerVie Health as changes occur in my medical history.

Signature _____ Date _____

Patient Name _____ DOB _____

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

Patient Name_____ DOB_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. Updated as of 8/13/2021

This Notice of Privacy Practices ("Notice") is provided in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). AllerVie Health, including its affiliates, (herein referred to as the "Practice") is required by law to take reasonable steps to ensure the privacy of your medical information, as defined below.

As used in this Notice, medical information refers to your "Protected Health Information," which includes all "Individually Identifiable Health Information" transmitted or maintained by the Practice, regardless of form (oral, written or electronic). The term "Individually Identifiable Health Information" means information that:

- Is created or received by a health care provider, health plain, employer or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

WHO WILL FOLLOW THIS NOTICE. This Notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group, which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the Notice that is currently in effect. Other ways we may use or disclose your medical information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Uses and disclosures not described in this Notice will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can be paid for treating you. We may also disclose your medical information to your health insurance plan to permit it to make a determination of eligibility or coverage for insurance benefits, to review the services we provided to you for medical necessity, and to perform utilization review activities. We may also disclose medical information about you to the responsible party of your account. If you are listed as a dependent on another person's insurance policy, financial information regarding medical

care provided may be mailed to that responsible party. In addition, if you do not timely pay us for the health care services we provided to you, we may also disclose limited medical information to a collection agency. We may also disclose your medical information to other health care providers, health plans or health care clearinghouses for their payment activities. For example, we may provide your medical information to an ambulance/transportation company that provided services to you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, our doctors and nurses may use and disclose your medical information with each other to provide treatment to you.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

Business Associates. We may disclose your medical information to our business associates that assist us in our delivery of health care and related services, such as billing companies, lawyers, accountants and others. Before we disclose your medical information to our business associates, we will have a written contract with each of them that will require each of them to agree to maintain the privacy of your medical information.

Below are other reasons we may use and disclose your medical information without your consent or authorization:

Uses and Disclosures Required by Law. We may use or disclose your medical information as required by law, but must limit such use or disclosure to relevant information and otherwise comply with applicable legal requirements. We must also disclose your medical information to the Secretary of Health and Human Services to determine our compliance with federal privacy laws.

Public Health Activities. We may use or disclose your medical information to public health authorities authorized to receive or collect information for public health purposes, such as for preventing or controlling disease and certain regulatory activities of the Food and Drug Administration.

Abuse, Neglect, or Domestic Violence. We may use or disclose your medical information in some instances if we reasonably believe that you are a victim of abuse, neglect, or domestic violence.

Health Oversight Activities. We may use or disclose your medical information to a health oversight agency for health oversight activities authorized by law, including, for example, inspections and licensure of health care facilities.

Judicial and Administrative Proceedings: We may use or disclose your medical information under certain conditions to comply with legal proceedings, such as a subpoena or order by a court or administrative tribunal.

Law Enforcement Purposes. We may use or disclose your medical information for law enforcement purposes to law enforcement officials, such as for identification of suspects or where a crime has been committed on our premises.

Decedents. We may use or disclose medical information about decedents to coroners, medical examiners, funeral directors, and other individuals involved in your care.

Research. In limited circumstances, we may use and disclose your medical information to conduct medical research.

Serious Safety Threat. We may use or disclose your medical information where we believe it is necessary to prevent or lessen a serious threat to the safety of a person or the public.

Workers' Compensation. We may use or disclose your medical information as authorized by and to the extent necessary to comply with laws related to workers' compensation and similar programs.

To Your Personal Representatives and Family Members. We may disclose your medical information to your personal representatives that are appointed by you or authorized by applicable law. We may disclose your medical information to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. In an emergency situation and if you are incapacitated, you will be given the opportunity to agree or object when it becomes practicable.

We will not use or disclose your medical information for any other purpose unless you give us written authorization to do so. If you give us written authorization to use or disclose your medical information for a purpose that is not described in this Notice, then, in most cases, you may revoke it in writing at any time.

Your revocation will be effective for all your medical information that we maintain, unless we have taken action in reliance on your authorization.

Below are some of the circumstances when we may use and disclose your medical information only with your authorization:

Psychotherapy Notes. With limited exceptions, your authorization is required for use or disclosure of psychotherapy notes, which are notes recorded by a mental health professional documenting the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

Marketing. With limited exceptions, your authorization is required for use or disclosure of your medical information for marketing purposes.

Sale of Your Medical Information. Your authorization is required if we want to sell your medical information.

NOTICE OF INDIVIDUAL RIGHTS. You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask the Practice to give you a copy of this Notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask the Practice to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Receive a Notification in the Event of Breach. You have the right to receive notification from the Practice in the event there is a breach related to your medical information.

CHANGES TO THIS NOTICE. We reserve the right to change this Notice. We will post a copy of the current Notice in the Practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Heather Guarnera, Privacy Officer, 214-227-8112, at 4975 Preston Park Blvd, Suite 800 Plano, TX 75093. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this Notice or would like to receive a more detailed explanation, please contact our Privacy Officer.