For Official Use Only

Patient #_____ Location_____ Photo ID Verified ❑

Date of First Appointment_____

PLEASE PRINT

PATIENT INFORMATION

Patient's Name: _____ Home Phone # _____

Address: _____ Cell Phone # _____

Street City State Zip

Best number for messages:

E-Mail Address: _____ Home ❑ Cell ❑

Date of Birth:_____ SEX: Male ❑ Female ❑ Relationship Status:_____ Social Security # _____

Have you or any other family members received medical care by our practice? If so, Who:_____ When: _____

EMERGENCY CONTACT:_____ Relationship:_____ Contact Phone # _____

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone ( ) _____

Address: _____ Fax # ( ) _____

Street City State Zip

Specialist/Other: _____ Phone ( ) _____

Address: _____ Fax # ( ) _____

Street City State Zip

Written report(s) will be sent to above Physicians unless otherwise noted; I give permission, PCP: Yes ❑ No ❑ Specialist/Other: Yes ❑ No ❑

How did you first hear about Colorado Allergy and Asthma Centers? (Check One)

❑ Primary Care: as above ❑ Internet Search ❑ Google® ❑ Friend _____

❑ Specialist: as above ❑ Advertisement ❑ CAAC Patient _____ ❑ Other _____

❑ Insurance Company ❑ Radio ❑ Family Member _____

EMPLOYMENT INFORMATION

Patient OR parent/guardian of a minor

Name: _____ Relationship: _____

Date of Birth: _____ SSN # _____

E-mail Address: _____

Employer: _____ Phone # _____

Employer Address: _____

City: _____ State:_____ Zip: _____

Spouse/Significant other OR the second parent/ guardian of a minor

Name: _____ Relationship: _____

Date of Birth: _____ SSN # _____

E-mail Address: _____

Employer: _____ Phone # _____

Employer Address: _____

City: _____ State:_____ Zip: _____

INSURANCE INFORMATION (Primary)

Ins Company:_____ Phone #_____

Policy Holder/Subscriber: _____

Subscriber Address: _____

Subscriber Date of Birth: _____ SSN # _____

Subscriber Relationship: _____

Ins Address: _____

Member/ID #_____ Group: _____

INSURANCE INFORMATION (Secondary)

Ins Company:_____ Phone #_____

Policy Holder/Subscriber: _____

Subscriber Address: _____

Subscriber Date of Birth: _____ SSN # _____

Subscriber Relationship: _____

Ins Address: _____

Member/ID #_____ Group: _____

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I authorize the release of any information necessary to process claims. I request payment of benefits to Colorado Allergy and Asthma Centers. I understand I am financially responsible for charges not covered by this authorization.

I understand and agree if care at Colorado Allergy and Asthma Centers requires Primary Care Physician referral, it is my responsibility to see that the referral is current prior to receiving care at Colorado Allergy and Asthma Centers. If no referral is present in advance, I agree to pay for charges at the time of service.

Patient/Guardian Signature _____ Relationship to Patient_____

Witness_____ Date_____

Consent for care of minors

Because my son/daughter is a minor (less than eighteen (18) years of age) and primarily supported by parent or guardian, I understand and agree that he/she may be evaluated and/or treated by Colorado Allergy and Asthma Centers' staff if I am not present to give consent. This may include, but necessarily limited to, physical exams, skin tests, laboratory test, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature _____ Relationship to Patient_____

Witness_____ Date_____

Colorado Allergy and Asthma Centers, P.C. **New Patient History**

Complete the following information. Please put an **X** in each box that relates to your problems. Use additional page to answer any questions if more room is needed.

Patient Name: _____ Date of Birth: _____ Date of First Visit: _____
(Please Print)

Were you referred by a physician or other provider? ☐ no ☐ yes If yes, who _____

Briefly state what problems are bringing you here: _____

Upper Respiratory Tract (Nose, Sinus, Ear, and Eye) Problems

Note: If No UPPER Respiratory Tract problems, Check Here ☐ And Go To Page 2 - Lower Respiratory Tract.

When did these symptoms first begin? _____

☐ sneezing ☐ itching nose ☐ runny nose
☐ nasal congestion ☐ stuffiness ☐ post-nasal drip
☐ decreased or absent sense of smell
☐ nose bleeds ☐ snoring
☐ nasal polyps; if so: ☐ past ☐ present
☐ drainage cough ☐ sore throat
☐ itchy throat ☐ bad breath
☐ frequent colds; if so, how many per year? 1-5 ☐ 5-10 ☐
☐ headaches/sinus pain _____
☐ recurrent ear infections ☐ ear plugging/popping/fullness
☐ hearing loss ☐ dizziness
☐ septum deviated ☐ septum perforated

☐ previous nasal or sinus surgery
☐ recurrent or chronic sinus infections; if so, how many per year?
☐ 0-4 ☐ over 4
☐ sinus x-rays or sinus CT scan done
- if so, when? _____
- result ☐ normal ☐ abnormal

☐ ENT evaluation; if so, when? _____
- name of doctor: _____

Eyes: ☐ itch ☐ red ☐ watering ☐ swollen lids
☐ dark circles ☐ fatigue/tired ☐ poor concentration
☐ other: _____

_____
_____
_____
_____

Symptoms Caused Or Aggravated By:

☐ cold air ☐ weather
☐ odors/scents/fragrance ☐ tobacco smoke
☐ dusting/vacuuming ☐ musty odors/mold
☐ yard work/pollens ☐ being outdoors
☐ aspirin/related medications
☐ animals, list: _____
☐ other: _____

Year-round symptoms? ☐ yes ☐ no

Season(s) in which symptoms are **worst**: ("X" all that apply)
☐ spring ☐ summer ☐ fall ☐ winter

Symptoms worse: ☐ AM ☐ PM ☐ night

Symptoms interfere with: ☐ sleep ☐ exercise/activity
☐ missed school ☐ missed work

Symptoms are: ☐ improving ☐ worsening ☐ unchanged

List medications tried for **nose/sinus** symptoms (include prescription and over-the-counter oral medications and nasal sprays):

Current Medication	Does it work?	Past Medication	Did it work?
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no

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_____
_____
_____
_____
_____

Name_____

Lower Respiratory Tract (Chest, Lung) Problems

Note: If No LOWER Respiratory Tract Problems, Check Here ☐ And Go To Page 3.

When did chest symptoms first begin? _____

☐ chronic or recurrent cough ☐ coughing spells

☐ dry ☐ loose; is mucus coughed up? ☐ yes ☐ no

- if yes, is mucus colored? _____

☐ coughing up blood

☐ wheezing; when breathing ☐ out ☐ in

☐ chest tightness or pressure ☐ throat tightness

☐ shortness of breath ☐ difficulty taking a full breath

☐ cough or breathing problems interfer with sleep

☐ asthma diagnosed by a physician? Age:_____

☐ emergency room visit(s) for asthma; how many?_____

☐ hospitalized for asthma; how many?_____

☐ intensive care unit for asthma

☐ oral steroids (Prednisone, Medrol, Prednisolone) taken for asthma

- if so, number of times taken per year:

☐ 1 ☐ 2 - 3 ☐ greater than 3

- date of last use: _____

☐ history of recurrent bronchitis

☐ history of recurrent pneumonia

☐ history of recurrent croup

☐ previous chest x-ray or chest CT scan; if so, when?_____

- result: ☐ normal ☐ abnormal

☐ peak flow meter used; if so, best reading:_____

☐ pulmonary function (lung) test: ☐ yes ☐ no

☐ pulmonary (lung specialist) evaluation; when: _____

- specialist's name: _____

☐ Are you physically active on a regular basis (formal exercise, play sports, other types of physical activity)? ☐ yes ☐ no

☐ Do you experience a cough, wheeze, difficulty breathing during exercise/physical activity? ☐ yes ☐ no

☐ other symptoms (list): _____

_____

_____

_____

_____

Symptoms Caused Or Aggravated By:

☐ colds / upper respiratory infections ☐ sinus infections

☐ exertion / exercise; type:_____

☐ cold air ☐ weather change

☐ odors / scents / fragrance ☐ tobacco smoke

☐ eating / drinking ☐ heartburn / acid reflux

☐ emotional stress / anger ☐ laughing / crying / cough

☐ your workplace or school ☐ aspirin / related medications

☐ dusting / vacuuming ☐ musty odors / mold

☐ yard work / pollens ☐ being outdoors

☐ animals, list:_____

☐ other:_____

Year-round symptoms? ☐ yes ☐ no

Season(s) in which symptoms are **worst**: ("X" all that apply)

☐ spring ☐ summer ☐ fall ☐ winter

Symptoms interfere with: ☐ sleep ☐ exercise / activity ☐ missed school ☐ missed work

Symptoms are: ☐ improving ☐ worsening ☐ unchanged

List medications tried for **lower respiratory** symptoms (include prescription and over-the-counter oral, inhaled, and injected medications):

Albuterol ☐ inhaler ☐ nebulizer How often used?_____

Current Medication	Does it work?	Past Medication	Did it work?
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no

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_____

_____

_____

_____

_____

Name:_____

Skin Problems

Note: If No SKIN Problems, Check Here ☐ And Go To 'Previous Allergy Evaluation' below.

Skin Symptoms:

☐ eczema ☐ rash

When did skin/eczema symptoms first begin? _____

☐ itching ☐ excessively dry, scaly skin

☐ irritated red patches ☐ weepy, oozing rash

☐ recurrent skin infections

☐ other skin symptoms (list):_____

☐ welts/hives ☐ skin swelling

When did hives/swelling first begin? _____

☐ itching ☐ face swelling ☐ hand/foot swelling

☐ lip swelling ☐ tongue/throat swelling

☐ difficulty breathing from swelling

Location of eczema/rash/hives: ☐ arms ☐ legs ☐ trunk ☐ head ☐ neck

Frequency of above symptoms: ☐ daily ____ times per week ____ times per month ☐ other:_____

Do skin symptoms occur year-round? ☐ yes ☐ no

Season(s) in which above skin symptoms are worst: ☐ spring ☐ summer ☐ fall ☐ winter

Has a physician diagnosed your rash? ☐ yes ☐ no

- if yes, what was the diagnosis? ☐ hives ☐ eczema ☐ contact dermatitis ☐ other:_____

Have you seen a dermatologist for your skin problems? ☐ yes ☐ no

- if yes, name of doctor:_____ when seen:_____

List everything that causes or aggravates your skin symptoms:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List medications tried for **above** symptoms (include prescription and over-the-counter oral medications, creams, and ointments):

Current Medication	Does it work?	Past Medication	Did it work?
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no

Previous Allergy Evaluation(s): ☐ no ☐ yes Date(s):_____

Skin testing: ☐ no ☐ yes Blood testing for allergy: ☐ no ☐ yes Were you allergic? ☐ no ☐ yes

- if allergic, was it to: ☐ animals ☐ dust/mites ☐ pollen ☐ mold ☐ food ☐ other (list):_____

Allergist: Name: _____ State:_____

Previous allergy injection(s): ☐ no ☐ yes If yes, age or date(s) of treatment: _____

If yes, how long did you take shots? ☐ 6 month ☐ 1 year ☐ 2 years ☐ 3 years ☐ longer

- were allergy injections effective? ☐ no ☐ yes ☐ not sure
- adverse reactions to allergy injection(s)? ☐ no ☐ yes If yes, list:_____

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_____

_____

_____

_____

_____

Name:_____

Insect Sting Reactions: ☐ no ☐ yes If yes, insect(s) causing reaction: _____

- symptoms: ☐ large swelling at site ☐ hives ☐ breathing problems ☐ dizzy / lightheaded
  ☐ other (list): _____
- age or date when occured?_____ (Epi-Pen) Epinephrine/Adrenalin device prescribed? ☐ no ☐ yes

Drug Allergies / Intolerances: ☐ no ☐ yes

Name Or Type Of Medication	Reaction(s) Noted	When Did Reaction Occur? Age or Date	Is The Medication Completely Avoided?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Food Allergies / Intolerances: ☐ no ☐ yes

Food	Reaction(s) Noted	When Did Reaction Occur? Age or Date	Is The Food Completely Avoided?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Latex or Rubber Allergies / Intolerances: ☐ no ☐ yes

If yes, explain: _____

Past Medical History:

Flu vaccine: ☐ no ☐ yes Pneumonia vaccine: ☐ no ☐ yes T.B. test: ☐ no ☐ yes result: ☐ positive ☐ negative

Birth history (if patient is a child): ☐ normal ☐ premature ☐ problems at birth: _____

Hospitalization(s): ☐ none _____

Surgery(s): ☐ none _____

Serious injury(s): ☐ none _____

Other medical problems: _____

All Current Medications not already listed (Include Over-The-Counter and Supplements. Use additional page if necessary.)

Medication	Dosage	Frequency (how often)	Medication	Dosage	Frequency (how often)

Family History:

Do any close family members have the following? **Check the appropriate box below:** (even if mild or outgrown)

	Father	Mother	Brothers	Sisters	Children
Hay fever / Allergies	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Sinus trouble	☐	☐	☐	☐	☐
Migraine headache	☐	☐	☐	☐	☐

Other diseases that run in the family:

Immune problems ☐ yes ☐ no
Family member: _____

Cystic Fibrosis ☐ yes ☐ no
Family member: _____

Emphysema ☐ yes ☐ no
Family member: _____

Name:_____

Social History:

Has the patient ever smoked? ☐ no ☐ yes If yes, for how many years: _____

Current smoker? ☐ yes ☐ no If no, when did you quit: _____

- how much do/did patient smoke? Number of packs per day ☐ less than 1/2 ☐ 1/2 ☐ 1 ☐ 2 or more

Alcoholic beverages? ☐ no ☐ yes If yes, how often: _____

Marijuana or other "recreational" drugs? ☐ no ☐ yes If yes, how often: _____

Review of Systems: (check all that applies)

General

- ☐ Good general health
- ☐ Weight gain; past year: _____lbs.
- ☐ Weight loss: _____lbs.
  - dieting ☐ yes ☐ no
- ☐ Excessive tiredness
- ☐ Excessive thirst/drinking
- ☐ Recurrent fever
- ☐ Recurrent night sweats
- ☐ Pregnant
- ☐ Planning pregnancy within year
- ☐ Cancer history
  - type: _____

Eyes ☐ Does not apply

- ☐ Dry eyes
- ☐ Wear contact lenses
- ☐ Cataracts
- ☐ Glaucoma

Mouth/Throat ☐ Does not apply

- ☐ Excess dryness of mouth
- ☐ Excessive throat mucus*
- ☐ Throat clearing*
- ☐ Hoarseness or voice problems*
- ☐ Sensation of something stuck in throat*

Heart ☐ Does not apply

- ☐ Palpitation or pounding of heart
- ☐ Irregular heart beat
- ☐ Angina/chest pain/tightness
- ☐ History of heart attack
- ☐ Thrombophlebitis/blood clots
- ☐ Swollen ankles/feet
- ☐ Heart murmurs
- ☐ High blood pressure

Gastrointestinal ☐ Does not apply

- ☐ Difficulty swallowing*
- ☐ Heartburn/acid indigestion/reflux
  - stomach acid coming up*
  - frequency:_____
  - treatment:_____
- ☐ History of ulcer
- ☐ Frequent spitting up or wet burps (infants)
- ☐ Hiatal hernia
- ☐ Recurrent vomiting
- ☐ Frequent diarrhea
- ☐ Bloody or black stools
- ☐ Constipation
- ☐ Liver disease: _____
- ☐ History of Hepatitis
  - Hepatitis Type: ☐ A ☐ B ☐ C
  - if so, when diagnosed_____
- ☐ Other problems: _____
  _____
- ☐ GI specialist: _____
  - when: _____

Genitourinary ☐ Does not apply

- ☐ Frequent urination
- ☐ Kidney trouble
- ☐ Bladder infection
- ☐ Prostate problem (men)
- ☐ Kidney stones

Musculoskeletal ☐ Does not apply

- ☐ Painful or stiff joints
- ☐ Swollen joints
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis (age/injury related)
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Bone Density Test
  - date: _____

Endocrine ☐ Does not apply

- ☐ Thyroid gland problems
- ☐ Adrenal gland problems
- ☐ Diabetes
- ☐ Parathyroid disease

Neurologic ☐ Does not apply

- ☐ Sinus headache
- ☐ Migraine headache
- ☐ Tension headache
- ☐ Hyperactivity/ADD/ADHD
- ☐ Dizzy spells
- ☐ Fainting spells
- ☐ Convulsions/epilepsy/seizures
- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ Ever see a psychiatrist/psychologist?
  - ☐ Currently see one

Blood/Lymphatic ☐ Does not apply

- ☐ Blood disorder: _____
- ☐ Anemia
- ☐ Bruise easily
- ☐ Swollen lymph nodes _____
- ☐ Previous blood transfusion
- ☐ Risk factors for AIDS
- ☐ Testing for HIV
  - if so, result: ☐ positive ☐ negative

☐ **Other symptoms or medical problems** (list)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ROS reviewed with patient/parent
MD/PA Initials_____

Name:_____

Environmental History

How long has patient lived in Colorado?_____ What other states/countries has patient lived in? _____

Primary Home (for patient living in two homes, also complete "Second Home" below)

Type: ☐ house ☐ townhouse ☐ condominium ☐ apartment ☐ mobile home ☐ other: _____

Age of home: ☐ less than 10 years ☐ 10-20 years ☐ 20-50 years ☐ over 50 years Length of time in home:_____

Construction

Basement: ☐ none ☐ finished ☐ unfinished ☐ walkout ☐ dirt ☐ crawl space ☐ moisture problem

Heating and Cooling

Heat: ☐ forced air heat ☐ hot water or radiant heat ☐ electric heat ☐ woodburning stove ☐ Fireplace; ☐ wood ☐ gas

Cooling system: ☐ none ☐ central air ☐ window air conditioner ☐ swamp cooler ☐ attic fan

Central filter type: ☐ none ☐ fiberglass ☐ HEPA ☐ electrostatic Frequency of filter change or cleaning: _____

Room air filter: ☐ none ☐ HEPA ☐ electrostatic ☐ ion generator ☐ other:_____ • which room_____

Air Ducts cleaned: ☐ no ☐ yes If yes, when_____

Mold and Moisture

Humidifier: ☐ none ☐ furnace ☐ cold-mist ☐ ultrasonic ☐ steam

Water leak(s): ☐ none ☐ past ☐ current ☐ musty odor ☐ visible mold

Cleaning

Frequency of dusting: ☐ daily ☐ 2-3 times per week ☐ 1 time per week ☐ every 2 weeks ☐ less often

Frequency of vacuuming: ☐ daily ☐ 2-3 times per week ☐ 1 time per week ☐ every 2 weeks ☐ less often

Patient's Bedroom

Flooring: ☐ carpet ☐ wood ☐ tile ☐ linoleum ☐ area rug

Bed: Mattress: ☐ innerspring ☐ foam ☐ waterbed ☐ bunk ☐ futon

Pillow: ☐ feather (down) ☐ foam ☐ synthetic

Pets

☐ no ☐ yes

	Number	How Long Owned?	Type / Breed	Outside	Inside	Sleep in Bedroom
☐ Dog(s)	_____	_____	_____	☐	☐	☐
☐ Cat(s)	_____	_____	_____	☐	☐	☐
☐ Other(s)	_____	_____	_____	☐	☐	☐

Smokers (at your home)

☐ No one ☐ patient ☐ mother ☐ father ☐ husband ☐ wife ☐ other

Other Environments

Daycare: Number of days per week_____ ☐ Animals Number in room_____

Relatives' Homes: Number of days per week_____ ☐ Animals ☐ Smokers

School / Work: Number of days per week_____ ☐ Animals ☐ Smokers

Hobbies / Interests

_____

Occupation / School / Daycare

Type of work / school / daycare: _____

Kinds of materials exposed to at work / school: _____

Second Home (for patient living in two homes, please complete the following):

Time spent in second home: _____

Smokers:_____

Pets:_____

Other exposures: _____

I have reviewed page 1-6 with parent/patient. _____ Date_____

Physician / PA Signature

HIPAA Privacy Notice – Patient Acknowledgement
"Health Insurance Portability and Accountability Act"

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.

The Federal Government has required that your medical records remain private, confidential, and unavailable to anyone without your expressed written consent. Our medical record of your care remains the physical property of Colorado Allergy and Asthma Centers, P.C. The State of Colorado supports this law. Forms are used for you to authorize, in writing, the release of a copy of your specific medical records to another entity such as; physician, medical practice, or to an insurance company for treatment, payment, and operations of CAAC.

Health Care Operations

There remain certain operational activities, where, in the process of delivering medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals within this practice, without expressed written permission of each and every specific occurrence by you. Some examples include:

- Requesting Photo ID at your visit
- Taking and saving a photograph of the patient for the chart to be used for identification and medical treatment
- Calling / faxing / electronically communicating to your pharmacy for prescription authorization
- Calling your insurance carrier for billing and/or reimbursement purposes
- Faxing / mailing your insurance carrier documentation of care
- Calling / faxing / e-mailing your Primary Care Physician (PCP) with results of care or questions
- Handling of the mail, newsletters, claims, bills, referrals
- Requesting that the office / reception staff call, text, or email you to schedule an appointment, acquire a referral, or to inform you about medications that may have to be held for testing
- Medical staff leaving reasonable and limited messages informing you of potential treatment options such as lab or x-ray results
- Inform you of health-related benefits or services that may be of interest to you
- Verbal or written correspondence with insurance companies; yours and ours
- Discussing an opportunity to enroll you in ongoing Asthma Allergy Research; and/ or continuation in research studies/ clinical trials
- Routine inter-office communication between professional staff of this specialty practice to effectively manage your medical care

You may restrict disclosure of any part of your Private Medical Information from within this practice to any outside source or recipient, where not allowed by law: Federal, State or by Court Order. Please note that any unsecure electronic communication initiated by the patient/family is done so at their own risk

Your Rights under the Law:

You have the right to receive a notice about our privacy policy

The right to inspect your protected health information (PHI) with a provider in a private environment

The right to request a copy of PHI and to have returned to you in 30 days, unless notified in writing of 60-day return

The right to request a restriction on uses and disclosures of your protected health information

The right to request to receive confidential communications from the practice by alternative means or at an alternative location

The right to request an amendment of your protected health information

The right to request an accounting of disclosures of Protected Health Information (PHI)

The right to revoke or limit authorization

The right to be notified of a breach of your PHI

Please list by name and relation the person(s) that may receive messages or talk to us regarding patient's medical care.

_____ _____
Name/relation Contact Number

_____ _____
Name/relation Contact Number

_____ _____
Name/relation Contact Number

Practice Duties

It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "needs to know" basis, and then kept confidential for your assurance that we comply with the Federal, State, and local laws on "Confidentiality of Medical Information."

Patient Name (label) _____

ACKNOWLEDGEMENT

I, _____ (patient, responsible party), acknowledge that I have received a copy of Colorado Allergy and Asthma Centers P.C.'s (the practice's) "HIPAA Privacy Notice-Patient Acknowledgment" document regarding protection of Personal Health Information (PHI).

Patient's or Responsible Party's Signature _____ Date _____

You may request at any time a detailed written policy of the Colorado Allergy and Asthma Center's P.C., "HIPAA Privacy Notice- Detailed" or access it at www.coloradoallergy.com

Financial Policy

Please review this information and sign at the end of the document. By signing this document, the patient/responsibility party is accepting financial responsibility for all services provided.

Colorado Allergy and Asthma Centers (CAAC) will bill your insurance as a courtesy if the company is within the United States. We may provide an estimate of what your insurance company may pay. The insurance company makes the final determination of your eligibility and benefits.

It is your responsibility to notify our office of any patient information changes including address, name, and insurance information.

Insurance Accounts

1. I (patient or financially responsible party) will disclose all insurance information including primary and secondary insurance at the time of service. Failure to provide complete insurance information may result in my responsibility to pay the entire bill.
2. I agree to pay any portion of the charges not covered by my insurance within 10 days of the statement date. If CAAC is out of network with my insurance company, I will be responsible for any charges above what is paid by my insurance up to the CAAC set fee amount. If my insurance pays me directly, I agree to forward the payment to CAAC immediately.
3. I am responsible for any co-payments, co-insurances, deductibles, plus any balance due on non-covered services not paid by my insurance at the time of service. Payments are required within the state's time limitation for paying healthcare claims. The co-payment, co-insurance or deductible requirement cannot be waived. We accept cash, check or credit cards.

Self-Pay Accounts

If you do not have insurance or you choose to not utilize your insurance, we offer a self-pay discount of 25% if payment is received in full at the time of service. Self-pay accounts are for all services for the entire year, or until new insurance is initiated due to a qualifying event.
No Exceptions.

Referrals

1. I am responsible for obtaining a referral, if required by my policy.
2. I understand if I fail to obtain the referral and/or preauthorization there may be a lower payment or no payment from the insurance company. I will be responsible for the balance due.

Missed Appointments

I understand I may be charged a fee of $75.00 if I miss or cancel an appointment within 24 hours of the scheduled appointment.

Returned Checks

I understand I will be responsible for a fee of $35 for a returned check. This will be applied to my account in addition to the insufficient funds amount. All future payments must be paid with a debit/credit card or cash.

Medical Record Copies

I understand I will be responsible for a fee that follows Colorado Department of Health and Environment standard for requesting a copy of my health records.

Minor Patients

1. By signing this document, I (the parent, guardian) accept financial responsibility for all services provided by CAAC, regardless of who is the subscriber of the insurance policy.
2. I understand as the adult (parent, guardian) accompanying a minor, I am responsible for charges at time of service (such as co-payment or deductible).

A divorce decree does not determine which party Colorado Allergy and Asthma Centers, P.C. will bill for medical services. Divorce decrees are only binding upon the two parties who made the agreement.

Payments

1. I understand that I am requested to put a credit, debit or HSA card on file. This information is kept strictly confidential and will only be used for payment of fees to CAAC. The card on file will not be charged until the insurance company has reviewed the claim. By processing insurance first, patients will know their exact out-of-pocket responsibility. After the insurance company has completed processing the claim, I will receive an email informing them of the actual amount owed. The email will explain that the card on file will be charged in 3-5 days unless I contact the billing office at 720-858-7550.
2. I understand the Financial Information may be provided to the financially responsible party (Guarantor), Subscriber, or the party paying the bill.
3. I understand the financially responsible party (Guarantor) is responsible for payments
4. I understand upon default, I am responsible for 24% per annum interest, cost of collections, and attorney fees, even if no lawsuit is filed.

Extended payment arrangements are available if needed. Please contact an Account Manager in our Patient Finance Office at 720-858-7550 to discuss payment options.

Please call our Patient Finance Office at 720-858-7550 with any questions or concerns.

I have read the policies above and understand and agree to this Financial Policy.

_____
PRINTED Name of Financially Responsible Party

_____ _____
Signature of Financially Responsible Party Date

_____ _____
Witness (CAAC Employee) Date

COLORADO ALLERGY & ASTHMA CENTERS, P.C.

Breathe Better - Live Better!

MEDICATION ALERT

For skin testing, **hold** any of the following medications or any other over-the-counter or prescription medication, containing an antihistamine, **for at least 7 days:**

Allegra (Fexofenadine)
Alavert (Loratadine)
Actifed
Antivert (Meclizine)
Atarax (Hydroxyzine)
Benadryl (Diphenhydramine)
Chlor-Trimeton (Chlorpheniramine)
Clarinex (Desloratadine)
Claritin (Loratadine)
Dallergy
Dimetane
Dimetapp
Doxepin (Silenor)
Dramamine
Duravent-DA
Pamprin Max Strength (Pyrilamine maleate)
Periactin (Cyproheptadine)
Phenergan (Promethazine)
Rondec
Sudafed Cold
Tavist (Clemastine)
Tylenol PM
Vertin (Meclizine)
Xyzal (Levoceterizine)
Zyrtec (Cetirizine)
Zzzquil (Diphenhydramine)

Any "PM," "Cold," or "Allergy" Medication

Eye drops: May contain Antihistamine:

Alamast, Alocril, Alomide, Bepreve, Elestat, Lastacaft, Naphcon-A, Optivar, Opcon-A, Pataday, Patanol, Pazeo, Zaditor or OTC Brands

Nose Sprays Containing Antihistamine: Astelin (Azelastine), Astepro, Dymista, Patanase

7 Day Hold:

Axid (Nizatidine) Pepcid (Famotidine) Tagamet (Cimetidine) Zantac (Ranitidine)

Do not stop medication you have been prescribed for other chronic medical conditions, such as heart and lung problems, or inhaled medications for your chest or nose. Do not stop asthma medications. Do not stop Singulair.

Call prescribing doctor for instructions on holding the medications listed below. May interfere with skin testing. Hold for 5 days before appointment.

Antidepressants/Anti-psychotics:

Asendin (Amoxapine)
Ativan, Temesta, Tavor, Lorabenz (Lorazepam)
Desyrel, Oleptro (Trazodone)
Doxepin, Silenor Elavil (Amitriptyline)
Ludiomil (Maprotiline)
Medazepam (Nobrium)
Norpramin (Desipramine)
Pamelor (Nortriptyline)
Remeron (Mirtazapine)
Risperdal (Risperidone)
Rivotril, Klonopin (Clonazepam)
Seroquel (Quetiapine)
Surmontil (Trimipramine)
Tofranil (Imipramine)
Vistaril (Hydroxyzine)
Vivactil (Protriptyline)

Cogentin (benztropine): For Parkinson's Disease, antihistamine properties

Some tranquilizers, cough medications, and sleeping aids may contain an antihistamine.
If you have questions about the content of any medications, please call your doctor, pharmacist, or us.

4/2018