

NEW PATIENT REGISTRATION

Tri-Cities Allergy Clinic, P.C.
James E. Mallette, III, DO

Patient Information

Full Name:		Date of Birth:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F				
Street Address:		City:		State:		Zip:		
Phone:		Email:			SSN:			
Race: <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other								
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Emergency Contact Name:				Relationship:				
Emergency Contact Phone:								
Employer Name:				Employer Phone:				
Employer Street Address:			City:		State:		Zip:	
Please tell us how you heard about us:					Referred by:			

Guarantor Information

(Please complete information for both parents if patient is a minor)

Mother Full Name:		Date of Birth:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F			
Address:		City:		State:		Zip:	
Phone:		Email:			SSN:		
Employer Name:			Employer Phone:		Occupation:		
Father Full Name:			Date of Birth:				
Address:		City:		State:		Zip:	
Phone:		Email:			SSN:		
Employer Name:			Employer Phone:		Occupation:		

Insurance Information

Primary Insurance Name:			
Policy Number/Subscriber ID:		Group #:	
Policy Holder Name (as it appears on card):		Policy Holder Date of Birth:	
<input type="checkbox"/> No Secondary Insurance			
Secondary Insurance Name:			
Policy Number/Subscriber ID:		Group #:	
Policy Holder Name (as it appears on card):		Policy Holder Date of Birth:	

Pharmacy Information

Pharmacy Name:		Pharmacy Phone:					
Pharmacy Address:		City:		State:		Zip:	

Referring Physician

Were you referred by another physician? Yes No

Referring Physician Name:		Referring Physician Phone:	
Primary Physician Name:		Primary Physician Phone:	

RELEASE OF INFORMATION TO FAMILY MEMBERS OR OTHER INDIVIDUALS

I authorize Tri-Cities Allergy Clinic, P.C. to discuss my medical information, appointments, prescriptions, billing information, and treatment plans with the following individuals:

- 1. Name: _____ Relationship: _____ Phone: _____
- 2. Name: _____ Relationship: _____ Phone: _____
- 3. Name: _____ Relationship: _____ Phone: _____

I do not authorize disclosure of my information to anyone other than myself and individuals otherwise permitted by law.

→ **Patient/Representative Initials:** _____

CONSENT TO TREAT

I voluntarily consent to receive medical care, treatment, diagnostic procedures, allergy testing, pulmonary function testing, immunotherapy, injections, and other healthcare services deemed medically necessary by the providers and staff of Tri-Cities Allergy Clinic, P.C. I understand that the practice of medicine is not an exact science and that no guarantees have been made regarding the results of my treatment. For minor patients, I certify that I am the parent, legal guardian, or authorized representative and consent to treatment on behalf of the patient. → **Patient/Representative Initials:** _____

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I authorize payment of medical benefits directly to Tri-Cities Allergy Clinic, P.C. for services rendered. I understand that I am financially responsible for all charges incurred regardless of insurance coverage, including but not limited to deductibles, copayments, coinsurance amounts, non-covered services, and services denied by my insurance carrier. I understand that insurance verification is not a guarantee of payment and that coverage determinations are made by my insurance company. I agree to provide current insurance information and understand that failure to do so may result in my being responsible for the full balance. I authorize Tri-Cities Allergy Clinic, P.C. to release medical information necessary to process insurance claims, obtain prior authorizations, and coordinate my healthcare. →

Patient/Representative Initials: _____

COMMUNICATION AUTHORIZATION

Tri-Cities Allergy Clinic, P.C. offers patients the option to receive certain information by text message and/or email. We are committed to protecting your privacy. The contact information you provide will be used only for communications related to your healthcare, appointments, billing, and services provided by our clinic. I understand that electronic communications may not always be secure and that standard messaging and data rates may apply. I may revoke this authorization at any time by providing written notice to the clinic. By signing below, I authorize Tri-Cities Allergy Clinic, P.C. to communicate with me via text message and/or email.

→ **Patient/Representative Initials:** _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Tri-Cities Allergy Clinic, P.C.'s Notice of Privacy Practices. The Notice of Privacy Practices explains how my protected health information may be used and disclosed, as well as my rights regarding my health information under the Health Insurance Portability and Accountability Act (HIPAA). I understand that the Notice of Privacy Practices is available to me upon request and may be updated from time to time in accordance with applicable federal and state laws.

→ **Patient/Representative Initials:** _____

I certify that I have read, understand, and agree to the foregoing authorizations, consents, acknowledgments, and financial policies.

Printed Name

Date

Patient/Parent/Legal Guardian Signature

Date

Patient's Name: _____ Age: _____ Date: _____

1. What is the major problem you wish to discuss today? _____

2. Chief Complaints (Check your main symptoms):

Head or Nose Symptoms		Chest Symptoms		Skin Symptoms
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Post-Nasal Drainage	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Chest Infection	<input type="checkbox"/> Hives
<input type="checkbox"/> Nose Blocking	<input type="checkbox"/> Red, Itchy, Watery Eyes	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Itching
<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Cough	<input type="checkbox"/> Hoarseness/Loss of Voice	<input type="checkbox"/> Eczema
<input type="checkbox"/> Headache	<input type="checkbox"/> Ear Blocking			<input type="checkbox"/> Swelling
Other not listed: _____				

3. Indicate the pattern of your symptoms:

Head/Nose

Chest

Skin

Year round, no seasonal variation

Year round, worse seasonally

Seasonal only

If seasonal, list the months: _____

4. Approximate age at onset:

Head or Nose Symptoms _____ Skin symptoms _____ Chest Symptoms _____

5. Do you note increased symptoms from any of the following: (Check Below)

Allergens		Irritants		Weather Changes
<input type="checkbox"/> Mowed Grass	<input type="checkbox"/> Mildew/Basement	<input type="checkbox"/> Smoke	<input type="checkbox"/> Feathers	<input type="checkbox"/> Windy Days
<input type="checkbox"/> Dead Grass	<input type="checkbox"/> House Dust	<input type="checkbox"/> Perfumes	<input type="checkbox"/> Detergents	<input type="checkbox"/> Damp Weather
<input type="checkbox"/> Dead Leaves	<input type="checkbox"/> Cats	<input type="checkbox"/> Paint	<input type="checkbox"/> Hair Spray	<input type="checkbox"/> Cold Fronts
<input type="checkbox"/> Hay	<input type="checkbox"/> Dogs	<input type="checkbox"/> Soaps		<input type="checkbox"/> Temperature Change
<input type="checkbox"/> Spring Pollen	<input type="checkbox"/> Fall Pollen			<input type="checkbox"/> Outside Dust

Indicate anything else you have noticed increasing symptoms: _____

6. Do you use OTC (over the counter) eye drops, i.e. Visine, Pataday, Opcon to treat eye symptoms? Yes No

7. List medications you use for relief, including OTC (over the counter) medicines: _____

8. Do you use nose drops or spray? Yes No If so, how often? Occasionally Regularly

9. How often do you get sinus infections and how are they usually treated? _____

10. Have you ever had nose or sinus surgery? Yes No If so, where/when? _____

11. Have you ever had ear tubes or tonsillectomy? Yes No If so, where/when? _____

12. Have you had skin testing for allergy previously? Yes No If so, where/when? _____

13. Have you taken immunotherapy (allergy shots) before? Yes No If so, how long? _____

14. Is there any history of allergic diseases in the family tree? (Examples: asthma, hay fever, nasal polyps, hives, sinus, migraine, eczema)? Yes No If yes, please check one: Mother's side only Father's side only Both

ASTHMA HISTORY

1. Have you ever been diagnosed with asthma? Yes No If so, when? _____

2. If you have a cough or wheeze listed as symptom, how long has it been since you had a chest x-ray? _____

3. Do you cough, wheeze, feel tight in the chest or short of breath after exercise? Yes No

ENVIRONMENTAL HISTORY

Check all that apply

Do you live in a:	<input type="checkbox"/> House	<input type="checkbox"/> Apartment	<input type="checkbox"/> Condo	<input type="checkbox"/> Duplex	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Nursing Home		
What type of heating is in your residence?	<input type="checkbox"/> Electric	<input type="checkbox"/> Gas	<input type="checkbox"/> Oil	<input type="checkbox"/> Solar	<input type="checkbox"/> Wood Burning	<input type="checkbox"/> Window Unit		
What type of cooling is in your residence?	<input type="checkbox"/> Electric	<input type="checkbox"/> Central	<input type="checkbox"/> Window Unit	<input type="checkbox"/> Fans	<input type="checkbox"/> Window Unit			
What type of flooring is in your residence?	<input type="checkbox"/> Carpet	<input type="checkbox"/> Wood	<input type="checkbox"/> Tiles	<input type="checkbox"/> Vinyl	<input type="checkbox"/> Other:			
Do you have a basement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is basement damp?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Air Cleaner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a fireplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is it used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Humidifier?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have anyone that smokes living in your household?	<input type="checkbox"/> Yes <input type="checkbox"/> No							
Do you have potted plants inside your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, how many?					
Do you have any indoor animals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, how many?					
What kind? (Explain):								

OTHER ALLERGY HISTORY

- Are there any foods you cannot eat for reason other than taste? Yes No **If yes, which foods and why/explain what happens when you eat this food?** _____

- Do you have a history or currently suffer from eczema? Yes No
- Are you sensitive to latex, rubber, or other chemical products? Yes No **If so, please list:** _____
- Have you ever had an allergic reaction from the sting of a bee, wasp, yellow jacket, or hornet, other than local swelling at the site of the sting (Symptoms such as generalized itching, hives, swelling in areas remote from the sting, hay fever, asthma, nausea, vomiting, etc.)? Yes No **If so, describe your symptoms?** _____
- Can you take aspirin? Yes No **If so, describe your symptoms?** _____
- Are you allergic to any drugs? Yes No **If so, which drugs & what symptoms?** _____

- Do you smoke? Yes No **If so, how many packs per day?** _____ **How many years?** _____
- Do you drink? Yes No
- Are you allergic to any drugs? Yes No **If so, which drugs:** _____
- Is there anywhere you have visited on travel or vacation where your symptoms have improved or disappeared? Yes No
If so, list the areas: _____
- Do you have any other medical problems? Yes No **If so, please describe:** _____

Please list the following medical history:

Hospitalizations (Past 3 to 5 years)	
Reason	Date
1.	
2.	
3.	
4.	

Surgeries	
Reason	Date
1.	
2.	
3.	
4.	

Medications

Please list ALL CURRENT MEDICATIONS you are taking below:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.



Tri-Cities Allergy Clinic, P.C.

Dr. James E. Mallette, III, D.O.

Allergy Testing Consent

Please inform the staff prior to testing if you have taken any antihistamines in the past 5 days, including Pepcid or other medications that may affect testing results.

Allergy Skin Testing

During an allergy evaluation, it is frequently necessary to test to various materials to which you may be allergic. These tests are performed by introducing suspected allergens by prick (scratch) and/or intradermal injections (superficial injection into the dermis). A local reaction which may appear like a bug bite – red, raised, and itchy- suggests a positive test.

Allergy skin testing identifies allergens and allows your physician to develop a more effective treatment plan tailored to your individual allergens. The most definitive treatment for environmental allergies is immunotherapy. Immunotherapy is administered by injection (allergy injections) and is prepared especially for you based on your skin test results and symptoms. Immunotherapy is an elective therapy and you may choose not to receive it.

Patch Testing

Patch testing to certain materials and substances may be recommended depending on your symptoms. This involves placing small amounts of the substance against the skin and affixing them in place for 48-72 hours. The testing site is then monitored for local reaction. Your provider will determine if this is necessary for you and provide further information if necessary. Potential adverse events include rash at the site, infection, or delayed skin reactions.

Pulmonary Function Testing (Spirometry)

If indicated, you may be asked to perform spirometry to assess your lung function. This involves taking a deep breath, then exhaling forcefully into a sensor for as long as possible, then taking another deep breath in. Please inform staff if you have recently experienced a heart attack, abdominal, chest, or pneumothorax (collapsed lung).

Allergy testing and immunotherapy services typically will go toward your major medical deductible (not all insurance plans require a deductible to be met) before insurance will pay. Please make sure you have contacted your insurance company to find out your benefits PRIOR to services rendered. If your deductible has not been met and you receive allergy testing and/or immunotherapy services, your deductible and copays are due at the time services are rendered. If you need to set up a payment plan, please ask of one of our staff members to assist you.

In signing this statement, I acknowledge that I have read and understand the information contained in the consent form. I agree to proceed with allergy testing, if indicated. I consent to treatment of adverse reactions to allergy testing, should they occur. I have been able to ask and have my questions answered to my satisfaction.

Patient Guardian Print: _____ Relationship: _____

Patient/Guardian Signature: _____ Date: _____

Financial & Office Policy Agreement

We are pleased to serve you as your health care provider and are committed to your good health. Please understand that payment for our services is considered a part of your treatment and your obligation to us. The following is a statement of Financial Policies which we require you to read and sign prior to treatment.

FULL PATIENT PORTION PAYMENT IS DUE AT THE TIME OF SERVICE

Insurance Filing

Regarding insurance plans where we are a participating provider, all copayments & deductibles are due at the time services are rendered. You need to know your insurance policy in advance to know the portion of your visit for which you will be responsible. As a courtesy we will bill your insurance company for charges incurred at our clinic. We cannot bill your insurance company unless you give us timely clear and accurate insurance information. Your insurance policy is a contract between you and your insurance company- we are NOT a party to that contract. A quote of benefits and/or authorizations does not guarantee payment or verify eligibility. If your insurance carrier deems a service to be NOT covered by your insurance plan, you agree to be responsible for the balance of this service. It is your responsibility to know your benefits and to contact your insurance company to determine if our physician participates with your insurance and to obtain the appropriate referral authorization or precertification before your visit. In the event our clinic does NOT participate with your insurance plan, you will be fully responsible for the charges you incur, and must pay the full balance at the time services are rendered. We are a "non-network Tricare certified provider." **If you have new insurance or change insurance plans, you must provide us with clear and accurate insurance information within 30 days of your visit for your insurance to be billed. If information is provided after 30 days, you will be responsible for any visits that may have occurred.**

Alabama Medicaid Office Visit Limit

Alabama Medicaid generally limits most adult recipients to **14 physician office visits per calendar year**. This annual limit includes most physician office visits, including consultations and many specialty services. Telemedicine visits also count toward the annual visit limit. Once a patient has reached the annual Medicaid office visit limit, additional office visits may not be covered by Alabama Medicaid unless an exception or authorization has been approved. **Requests for additional physician office visits beyond the annual Medicaid limit must be submitted by the patient's Primary Care Provider (PCP), as required by Alabama Medicaid. As a specialty practice, Tri-Cities Allergy Clinic is not responsible for obtaining approval for additional office visits.** Patients who have reached their annual visit limit should contact their PCP to request authorization for additional covered visits before scheduling non-emergent appointments.

Self-Pay

All Self-Pay patients and patients who present without proof of insurance are required to pay their services at the time services are rendered. Payment plans may be made with a valid credit card, and separate agreement will be provided.

Statements

If you have a balance on your account after your date of service(s), you will receive statements and/or collection letters each month until payment in full is received on your account. Though we will try to remind you at each visit of any balance, it is ultimately your responsibility. When you receive an explanation of benefits from your insurance company showing any patient responsibility, you have received your first statement. If you do not make payment arrangements with our office in advance, we reserve the right to transfer your account to a collection agency once your account reaches 90 days old.

Financial Responsibility

Patient/Responsible party agree(s) that failure to make payment when due is the cause for legal action, and agree(s) to pay any and all costs of collection, which shall be in addition to the total outstanding amount owed by the Patient/Responsible party, including reasonable attorneys, and agree(s) that their obligations are joint and severable, permitting the P.C. to pursue either or both for payment. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. I, the undersigned, give Tri-Cities Allergy Clinic P.C., its employees and agents, express prior consent to contact me at any/all phone numbers, including cell phone numbers, for the purpose of treatment, insurance and/or payment. If your account accrues a credit balance, we will maintain that balance on your account and apply it to any future balance which may accrue. Small credit balances carried forward for more than two calendar years will be adjusted.

Forms

There is a charge for all completed medical forms and letters. Simple letters and forms incur a fee of **\$5.00 per form** (ex: school medication forms). The fee will be increased to \$25.00 for more detailed and lengthy forms and letters (ex: FMLA, Military Forms/Letters).

Minor Patients

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. If a balance accrues at any time, it is your financial responsibility to arrange ahead of time to transfer copayments, coinsurance amounts, and deductibles to the parent or guardian who brings the child to the office.

Divorced Parents/Legal Custody Issues

The adult accompanying their child to our office for an appointment is responsible for payment. Arrangements for court orders or any legal payment arrangements amongst parents must be worked out BEFORE your appointment. If a separate parent is responsible for payment, we are not a party to this arrangement. Payment is due in full at the time of appointment, and we will prepare receipt of payment for verification purposes.

Forms of Payment Accepted

We accept cash, check, debit cards and all major credit cards (including CareCredit). In addition, you can pay balances due on your account securely via credit card using the "Pay Online" link on our website at: www.tricitiesallergyclinic.com. There will also be a QR code located at the top of your monthly statement that will direct you to our website for payment. Our office charges a returned check fee of \$35.00 on ALL returned checks. Patients which are dishonored will be required to pay future amount due with cash, money orders, or debit/credit card.

Payment Plans

We require a card on file in order to qualify for a patient payment plan. To see if you qualify for one of our patient payment plans, please call our office at 256-767-1701 to speak with one of our staff members. A patient payment plan must be agreed upon and a separate agreement will be filled out prior to any services rendered.

Postage Fees/Extract Ordering

For all mailed extract orders, there is a **\$10.00 postage fee**. This office reserves the right to change its fees at any time without prior notice. All past due balances must be paid prior to any new extract charges being added to your account. Address changes must be communicated to Tri-Cities Allergy Clinic in writing and written on the reorder form so that the extract will be mailed to the correct address. Failure to do so will result in your having to pre-pay the full amount for the replacement vial(s) as we will not be able to bill them to insurance.

Bankruptcy

If an account is uncollectable due to bankruptcy, future services must be paid in full at the time of service.

Missed Appointments/Cancellations

Returning patient missed appointments, unless canceled **at least 24 hours in advance**, will incur a no-show fee of **\$25.00**. Any new patient appointments or missed appointments with testing orders will incur a no-show fee of **\$50.00**. Please help us serve you better by keeping scheduled appointments.

Patient Dismissal Policy

Patients can be dismissed from this practice for the following reasons: (1) Three or more "no-show" or "same-day cancellation" appointments (2) Not complying with their prescribed medical care (3) Being disrespectful, hostile, or verbally/physically abusive to ANY clinic staff at any time (4) Not paying for services. A patient who is dismissed from the practice will be notified via letter sent by certified mail to the address on record. Following dismissal, a patient will be provided with any necessary emergency care for 30 days starting from the date the dismissal letter was mailed.

Convenience Fee

Effective February 1, 2026, a convenience fee of 3% will be added to all Debit and Credit Card transactions. This fee percentage amount is subject to change at the discretion of Tri-Cities Allergy Clinic, P.C. A notice will be posted if such a change.

By signing this consent form, I am consenting to allow Tri-Cities Allergy Clinic, P.C. to use and disclose my protected health information for treatment, payment, and healthcare operations (this also includes your pharmacy).

By signing this consent form, I am consenting to allow Tri-Cities Allergy Clinic, P.C., to release information necessary to file insurance claims and assign benefits otherwise payable to the policyholder or group indicated on the claim or request for payment. I understand that I am financially responsible for balances not covered by my insurance carrier and that a copy of any signature is valid as the original.

I have read the Financial Policies of Tri-Cities Allergy Clinic, P.C. and agree to its terms.

Print Patient/Guardian Name: _____ Relationship to Patient: _____

Patient/Guardian Signature: _____ Date: _____