NEW PATIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Female ____ Male ____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed _____

Have other family members been a patient or presently patient's at this clinic: Yes ____ No _____

If yes, please list name(s): _____

If Patient is a Minor:

Father's Name: _____ Date of Birth: _____

Father's Social Security Number: _____ Single ____ Married ____ Divorced ____ Widowed___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name: _____ Employer Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Date of Birth: _____

Mother's Social Security Number: _____ Single ____ Married ____ Divorced ____ Widowed___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name: _____ Employer Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

If Patient is an Adult:

Employer Name: _____ Employer Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouses Name: _____ Date of Birth: _____ SSN: _____

Spouses Employer Name: _____ Employer Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ City: _____ State: _____

Family Physician: _____ City: _____ State: _____

Nearest Relative Name: _____ Phone Number: _____

Name of Insurance Company: _____

Name of Insured: _____ **Insured Date of Birth:** _____

Insurance ID/Contract Number: _____ **Group/Policy Number:** _____

Relationship to the patient: Self _____ Spouse _____ Child _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. You have a right to review our Notice of Privacy Practices, which provides a more complete description of the uses and disclosures that we are permitted or required by law to make. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Effective April 14, 2003 due to federal regulations HIPAA, we are required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationships, and phone numbers of any authorized individuals with whom we may discuss your medical or financial information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient or Legal Representative: _____ **Date:** _____

I authorize the release of medical information to process claims. I authorize payment of medical benefits to the physician or supplier as described on claim.

I understand that some or all of the services provided by this office may be deemed medically unnecessary by Medicare or my Insurance carrier and payment denied by them. I, as a patient or patient's legal representative agree to be responsible for all charges covered or not covered by Medicare or my Insurance carrier. I also agree to take FULL RESPONSIBILITY for any allergy extract mailing fees or any extract lost in the mail.

Patient or Legal Representative: _____ **Date:** _____

PATIENT EMAIL AND/OR TEXT MESSAGING CONSENT

Due to the changing world of healthcare and technology, Tri-Cities Allergy Clinic now has the ability to provide our patients with certain types of information via text messaging. If you wish to have the opportunity to receive information this way, please complete the form below.

Tri-Cities Allergy Clinic believes strongly in protecting the privacy of our patients. When you provide this information to use, it is only used as a way to communicate with you. I hereby authorize Tri-Cities Allergy Clinic permission to send messages to me via email and/or text messaging as a means of communication.

Patient/Legal Representative: _____ **Cell Phone:** _____

Referring Physician _____

Patient's Name _____ Age _____

Date _____

1. Chief Complaints: (Check your main symptoms)

Head or nose symptoms

a. Sneezing ☐
b. Nose blocking ☐
c. Runny nose ☐
d. Post-nasal drainage ☐
e. Sinus infection ☐
f. Sore throat ☐
g. Ear blocking ☐
h. Headache ☐
i. Red, itchy, watery eyes ☐

Chest symptoms

a. Cough ☐
b. Wheezing ☐
c. Shortness of breath ☐
d. Chest infection ☐
e. Hoarseness or loss of voice ☐

Do you use OTC drops, i.e. Visine, Naphcon, Opcon to treat eye symptoms? Yes ☐ No ☐

Skin symptoms

a. Hives ☐
b. Eczema ☐
c. Itching ☐

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2. Approximate age at onset: Head or nose symptoms _____ chest symptoms _____
Skin symptoms _____

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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 months: _____

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4. Is there any area where you have visited on travel or vacation where your symptoms have improved or disappeared? Yes ☐ No ☐
If so, list areas: _____

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5. Are you allergic to any drugs? Yes ☐ No ☐ If so, list drugs: _____

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6. List medicines you use for relief: _____

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7. Have you ever had allergic symptoms 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 ☐

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

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9. Have you had skin testing for allergy previously? Yes ☐ No ☐
If so, give name and location of doctor doing the testing: _____

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10. Have you taken hyposensitization shots ("allergy shots") previously? Yes ☐ No ☐
If so, for how long: _____

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11. Is there any history of allergic disease in the family tree?
(Examples: asthma, hay fever, nasal polyps, hives, "sinus", migraine, eczema, Catarrh)
Yes ☐ No ☐ If so: Mother's side of the family only ☐ Father's side of the family only ☐
Both sides of the family ☐

12. Do you have pets at home? Yes ☐ No ☐ If so, what kinds?_____
Kept outside completely ☐ Outside some, inside some ☐ Inside most of the time ☐

13. Do you note increased symptoms from any of the following? Yes ☐ No ☐ CHECK BELOW

a. Allergens

Mowed grass	☐	House dust	☐
Dead grass	☐	Cats	☐
Dead leaves	☐	Dogs	☐
Hay	☐	Feathers	☐
		Spring Pollen	☐
		Fall Pollen	☐
		Mildew/Basement	☐

b. Irritants

Damp weather	☐	Smoke	☐
Perfumes	☐	Paint	☐
Soaps	☐	Hair spray	☐
Detergents	☐	Outside dust	☐

c. Weather Changes

Windy days	☐
Cold fronts	☐
Temperature change	☐
Damp weather	☐
Outside dust	☐

d. Foods (List): _____

Indicate anything else you have noticed increasing symptoms _____

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

15. Do you smoke? Yes ☐ No ☐ If so, how many packs per day_____ and for how long?_____

16. Can you take aspirin? Yes ☐ No ☐

17. Previous hospitalization or serious illness not requiring hospitalization. List in order of most recent - (list only 5, if over 5 tell doctor)

Cause of Hospitalization	Age when Hospitalized
1.	
2.	
3.	
4.	
5.	

18. Do you have any other medical problems with:

	YES	NO
stomach, bowels	☐	☐
heart, blood pressure	☐	☐
nervous system	☐	☐
urinary tract	☐	☐
blood	☐	☐

19. List any medications (including over the counter drugs, creams, suppositories, etc.) you take with any regularity

_____

_____

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:** _____

Tri-Cities Allergy Clinic, P.C.
Dr. James E. Mallette, III
216 S. Marengo St. Suite H, Florence, AL 35630
P: 256-767-1701 F: 256-760-0496

Financial Policy/Clinic Policy

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. 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. **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.**

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
You need to know your insurance policy in advance to know the portion of your visit for which you will be responsible. If our office is forced to utilize an outside collection agency or attorney to collect an outstanding balance, we will add an additional fee of up to 50% of the debt incurred to your account. If court fees accrue, you will be responsible for these as well. 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**. 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.

I have read the Financial Policies of Tri-Cities Allergy Clinic, P.C. and agree to comply with the Financial Policies. I authorize Tri-Cities Allergy Clinic, P.C. to release any information required to process my claims.

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

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