Allergy
Asthma
& Sinus
Center, P.C.

Board Certified
in
Allergy and Immunology

Stephen A. Imbeau, M.D.
FACP, FAAAAI, FACAAI

Joseph G. Moyer, M.D.
FACAAI

H. David Stone, Jr., M.D.
FACAAI

Danny Douglas, M.D.

Timothy E. Crouch, M.D.

www.allergysc.com

1-800-253-6697

McLeod Medical Plaza
800 E. Cheves St. Suite 420
Florence, SC 29506
843-679-9335
fax 843-667-1700

South Strand Medical Center
5046 Hwy. 17 Bypass South
Suite 105
Myrtle Beach, SC 29588
843-293-5000
fax 843-293-4748

Seacoast Medical Center
3980 Hwy. 9 East
Suite 260
Little River, SC 29566
843-399-9033
fax 843-399-9051

701 Medical Park Drive
Suite 104
Hartsville, SC 29550
843-332-3191
fax 843-332-3801

Tuomey Medical Center
100 N. Sumter Street
Suite 405
Sumter, SC 29150
803-934-1488
fax 803-934-8878

Form 0104

WELCOME TO ALLERGY, ASTHMA AND SINUS CENTER, P.C.

I would like to welcome you as a new patient to our practice. We appreciate you choosing our practice for your care. We value your time and work very hard to ensure minimal wait time for all patients. If you have not been to our practice within a three-year period you are considered as a "new patient" again, per insurance regulations. Below you will read our practice's guidelines that you are required to follow.

It is imperative that you discontinue any drugs containing any form of antihistamine one week prior to your visit. If you are unsure of your medications, your pharmacist can assist you. I am attaching a medication sheet that list some of the medications that will help you to identify the ones you would need to discontinue taking one (1) week before your appointment.

If you find you are unable to meet your confirmed appointment, ***CALL US*** AT **843-679-9335** to reschedule. This will enable us to place another patient in your time slot within a week's notice. We understand true emergencies, but please understand that our "new" patient slots are allotted more time than a regular visit, so if you do not keep your appointment, it creates scheduling problems. If you fail to cancel your appointment within one week, you will be given only one other chance to schedule with us. Once you are considered an "established" patient, the same cancellation policy is required.

When scheduling your appointment over the phone or in person, you should listen closely to the person scheduling your appointment. She will discuss information with you of everything that is expected before your initial appointment. This will also include your identifying information and insurance card(s) to schedule your appointment according to your specific problems. If you were referred by your primary care doctor and they made the appointment for you, you will still need to call our office so we can provide information needed prior to your appointment. Please notice we have (5) office locations indicated on letterhead so you can call directly to the office at which you will be seen. When automated attendant provides you options, select ***APPOINTMENT***.

You are required to have your paperwork completed correctly before your appointment. If you need assistance with paperwork you will need to come in early of your set appointment to have the business office to assist you. You are required to present your photo ID and insurance card(s). We will file your visit to your primary and secondary insurance. You are expected to pay any portion not covered by your insurance(s) at the time of your visit. If you know that you are unable to pay, you will need to call the office to reschedule your appointment until you can meet our financial requirements. We will verify your insurance eligibility before your visit but you should do the same. The phone number is on the back of your insurance card and you can either call or go online to obtain this information. If you do not have insurance, you will be expected to pay the entire cost of the visit. We accept cash, debit, credit cards, and HSA cards.

It is also important that you keep your personal information current. If your phone number, address or other information changes so we are always able to reach you. You will also receive a friendly reminder call to verify your appointment. Reminder – it is your responsibility to follow AASC's cancellation policy. Thank you and if you have any questions, please call us.

Sincerely,

ALLERGY, ASTHMA AND SINUS CENTER, PC

Allergy
Asthma
& Sinus
Center, P.C.

Board Certified
in
Allergy and Immunology

Stephen A. Imbeau, M.D.
FACP, FAAAAI, FACAAI

Joseph G. Moyer, M.D.
FACAAI

H. David Stone, Jr., M.D.
FACAAI

Danny Douglas, M.D.

Timothy E. Crouch, M.D.

www.allergysc.com

1-800-253-6697

McLeod Medical Plaza
800 E. Cheves St. Suite 420
Florence, SC 29506
843-679-9335
fax 843-667-1700

South Strand Medical Center
5046 Hwy. 17 Bypass South
Suite 105
Myrtle Beach, SC 29588
843-293-5000
fax 843-293-4748

Seacoast Medical Center
3980 Hwy. 9 East
Suite 260
Little River, SC 29566
843-399-9033
fax 843-399-9051

701 Medical Park Drive
Suite 104
Hartsville, SC 29550
843-332-3191
fax 843-332-3801

Tuomey Medical Center
100 N. Sumter Street
Suite 405
Sumter, SC 29150
803-934-1488
fax 803-934-8878

Important Information For Your First Visit

- Please bring your current medical insurance card(s), valid picture ID and completed forms.
- Appointment Cancellation Policy: Many patients need our services. A last-minute cancellation deprives someone else of an appointment time. Please notify our office of a cancellation or request for an appointment change at least five (5 days) in advance of your appointment.
- Be prepared to pay your deductible, co-pay and/or co-insurance at the time of your visit. We participate with most major insurance companies. We accept Visa, Master Card, American Express, Discover, Personal Checks, Cash, Debit Cards and HSA Cards.
- If you are paying as a Self-Pay (Cash patient), all charges are due at time of your visit.
- Some insurance plans require a referral from your primary care physician; it is your responsibility to obtain a referral prior to your visit. Unfortunately, we will not be able to see you, if you do not have a referral at the time of your visit.
- Please arrive at least 15 minutes prior to your visit. If you are running late, please call our office, as a late appointment may require you to reschedule your appointment, for we may be unable to test you due to time constraints.
- New Patient appointments may take two (2) hours to complete. Therefore, it is important that you use the restroom or telephone before we begin testing. Skin test results will be discussed with you upon completion.
- It is important to stay off antihistamines for five (5) to seven (7) days prior to testing. Antihistamines will block the skin test reaction. *(See detailed list of medications included in the New Patient Packet and on our website.)*
- Allergy testing Procedures: Based on your symptoms, we may find it necessary to perform tests such as skin testing. Skin testing is performed by applying allergens to the skin and lightly pricking. The results may be raised, red, itchy spots which will appear within 15 to 20 minutes after being pricked. This reaction is similar to a mosquito bite and usually disappears within several days after testing. Reactions can indicate which allergens may be causing your symptoms. Skin testing is not painful but can be somewhat uncomfortable.
- After skin prick testing, some patients may also receive intradermal testing, where a small amount of the allergen is injected under the skin of the arm to see if it causes a reaction. The intradermal test feels like pinches.
- We need any relevant reports from laboratory studies, allergy testing, CT scans, or x-rays (blood work, CTs of sinuses, chest x-rays, etc. – not the films, just the reports) done in the past six months, if any. Please obtain copies of the reports, either bring them with you or have them faxed beforehand to the office location of your appointment.
- We do not accept walk in appointments, all appointments must be made by calling our office.
- A parent/legal guardian or another adult (with a signed Consent to Treat form) must accompany patients under 18 years old.

Medication Protocol

Longer Acting Antihistamines Stay off of these 5-7 days	Alavert Aleve PM Allegra (Fexofenadine) Allegra D (fexofinadine D) Astelin(nose spray) Atrohist Bromfed Bromhist Chlor Trimeton Claritin (cetirizine) D-Allergy Doxepin Histussin Lodrane Loratadine (cetirizine) Respa AR Vistaril Xyzal (Levocetirizine)
Shorter acting/over the counter antihistamines	Withhold 1 week (5-7 Days) prior to your appointment. Actifed Alavert Alka Seltzer Plus Allerest BC Cold Powder Benadryl Nyquil Comtrex Coricidin(D) Cyproheptadine Dimetapp Diphenhydra Drixoral Optimine Panmist Jr. Pediacare Periactin Phenergan Rondec (TR) Rynatan Sinarest Sinutab Sudafed Plus Tavist Tavist D Thera Flu Triaminic Trinalin Tylenol Cold or Flu Tylenol Plus Vicks
Over The Counter Sleep aids	Advil PM Compoz Excedrin PM Night time Sleep Nytol Sleepinal Sominex Tylenol PM Unisom
Anti-Itch Medications: withhold 4 Days	Atarax(Hydroxyzine) Anti Disorder Medication: Withhold 4 Days Prior **Please contact your prescribing doctor and ask if it is ok to withhold your medication** **Examples:** Ativan Effexor Elavil(Amitriptyline) Eliquis Pamelor(Nortriptyline)
Medications That are ok to continue	**All Asthma medications are ok (Advair, Albuterol, Ventolin, ect.)All creams and ointments, antibiotics, Decongestants(Guiafed, Duratuss, Intex), Nasal sprays except Astelin, Singulair, Decadron, Prednisone , Wellbutrin, Mucinex D, Ritalin,Zantac**

DRIVER'S LICENSE_____

CHART# _____

PATIENT INFORMATION

(Please complete every line)

EMAIL_____

DOCTOR _____

Welcome To Our Office

DATE_____

PATIENT'S NAME (Please Print)	MARITAL STATUS S M W D Sep	DATE OF BIRTH	AGE	SEX M F	RACE	SOCIAL SECURITY NO.

STREET ADDRESS or P.O. BOX	CITY AND STATE	ZIP CODE	HOME PHONE NO.
			CELL PHONE NO.
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (Indicate if Student)		WORK NO.
EMPLOYER'S MAILING ADDRESS	CITY AND STATE		ZIP CODE

DRUG ALLERGIES, IF ANY

SPOUSE OR PARENT'S NAME (Required for minors)	SOCIAL SECURITY NO.	DATE OF BIRTH	
INSURANCE (Primary)	GIVE NAME OF POLICY HOLDER	DATE OF BIRTH	SOCIAL SECURITY NO.
INSURANCE (Secondary)	GIVE NAME OF POLICY HOLDER	DATE OF BIRTH	SOCIAL SECURITY NO.

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S)? INCLUDE NAME OF FAMILY MEMBER AND PHYSICIAN

REFERRED BY OR FAMILY PHYSICIAN:	PREFERRED PHARMACY:

PLEASE READ: All Professional Services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/ Other Insurance company benefits be made either to me or on my behalf to ALLERGY, ASTHMA & SINUS CENTER, P.C. for any services furnished me by that party who accepts assignments physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare Other Insurance company claim.

I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare Other Insurance company assigned cases the physician or supplier agrees to accept the charge determination of the Medicare Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are base upon the charge determination of the Medicare Other Insurance company.

Signature_____ **Date** _____

PATIENT CONSENT FORM

The Department of Health and Human Services has Established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

Allergy
Asthma
& Sinus
Center, P.C.

Board Certified in Allergy and Immunology

Stephen A. Imbeau, M.D.
FACP, FAAAAI, FACAAI

Joseph G. Moyer, M.D.
FACAAI

H. David Stone, Jr., M.D.
FACAAI

Danny Douglas, M.D.

Timothy E. Crouch, M.D.

www.allergysc.com

1-800-253-6697

McLeod Medical Plaza
800 E. Cheves St. Suite 420
Florence, SC 29506
843-679-9335
fax 843-667-1700

South Strand Medical Center
5046 Hwy. 17 Bypass South
Suite 105
Myrtle Beach, SC 29588
843-293-5000
fax 843-293-4748

Seacoast Medical Center
3980 Hwy. 9 East
Suite 260
Little River, SC 29566
843-399-9033
fax 843-399-9051

701 Medical Park Drive
Suite 104
Hartsville, SC 29550
843-332-3191
fax 843-332-3801

Tuomey Medical Center
100 N. Sumter Street
Suite 405
Sumter, SC 29150
803-934-1488
fax 803-934-8878

Form 0104

Chart#_____

Authorization for Release of Information to Family and/or Friends

Patient Name _____ Date of Birth: _____

Allergy, Asthma, and Sinus Center, P.C. is authorized to release protected health information about the above-named patient to the entities named below.

Entity to Receive Information- INITIAL EACH that is subject to this authorization.

____ Leave information on the voicemail. ☐ Home ☐ Cell ☐ Work
____ Give information to spouse.
____ Give information to the following person(s):

_____ _____
(Name of person information can be released to) (Relationship to patient)

_____ _____
(Name of person information can be released to) (Relationship to patient)

Description of Information to be released

____ Financial information
____ Family billing information
____ Information results from test or x-rays.
____ Medical information as follows: _____
____ Other information as described: _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by signing a written notification to Allergy, Asthma & Sinus Center, PC. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing this authorization.

This Authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ _____
Signature of Patient or Personal Representative Date

Auth form 001

Consent for Treatment of a Minor Without a Parent or Legal Guardian Present

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Minors under age 16:

_____I understand that it is the policy of Allergy, Asthma & Sinus Center, P.C. that **minors under the age of 16 must be accompanied** to office visits or allergy shots **by a responsible adult**. If I am unable to accompany my child, I give permission for the following person /people to bring them instead:

_____ _____
Relationship to patient

_____ _____
Relationship to patient

_____ _____
Relationship to patient

Minors age 16 or older:

ALLERGY SHOTS (Consent for treatment):

_____ In the event that I am unable to **personally** accompany my above-named minor child to Allergy, Asthma & Sinus Center, P.C for their allergy shots, I give my permission for my child to travel on an unaccompanied basis to the office of Allergy, Asthma & Sinus Center, P.C for the allergy shots to be administered without my presence and also any treatment that might need to be given due to complications or adverse reactions that could occur from receiving the shots.

This also confirms that I have read and understand the allergy shot consent form (copy available upon request); have reviewed the consent with my child and have emphasized to my child the need to wait 20 minutes after the shot.

_____ _____
Printed name of Parent/Legal Guardian **Signature of Parent/Legal Guardian**

_____ _____
Witness Signature **Date**

NEW PATIENT CHECKLIST

ALLERGY, ASTHMA AND SINUS CENTER, PC

The following is a checklist of items we will need you to bring to your first visit. If you should have any questions please contact us at 843-679-9335.

_____ **LIST OF CURRENT MEDICATIONS**

_____ **ALL INSURANCE CARDS**

_____ **PATIENT REGISTRATION INFORMATION FORMS**

_____ **SIGNED MEDICAL RECORD RELEASE FORM**

Please be reminded:

1. **Avoid antihistamines 5 to 7 days prior to your scheduled appointment.**
2. **Plan for payment of any co-pay, co-insurance, or deductible at your appointment.**
3. **If patient is considered a minor, the patient must be accompanied by a parent or legal guardian.**

Thank you for completing the necessary information. We desire to make your first visit and all future visits pleasurable as possible. We appreciate your feedback at any time. You may visit our website at www.allergysc.com.

Allergy Asthma & Sinus Center

Financial Policy

Thank you for choosing Allergy Asthma & Sinus Center to provide you and/or your child with quality and affordable healthcare. This goal is best achieved if everyone is aware of our financial policy, which is an agreement between the practice and the patient/guardian. Your clear understanding of the financial policy agreement is important to our professional relationship. We require a signature to document that you have read and understand these policies.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENTS.

New Patients- Prior to your initial visit based on insurance benefits, allowables, verification and eligibility, you are expected to pay a ***minimum*** of $250.00, ***all or part*** of this will be for the office visit. There are additional charges for any testing (allergy or pulmonary). Additional testing will be performed as determined by the rendering physician at the time of the office visit.

Insurance/Payment-Payment for services is due at the time services are rendered, except as outlined as follows. Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. On arrival, please sign in at the front desk and **present your current Insurance card at every visit.** It is the responsibility of the patient/guardian to provide **accurate** insurance information. **Inaccurate information given to the staff that results in denial or non-coverage by your insurance company results in the guarantor being responsible for payment.** According to your contractual agreement with your insurance plan, you are responsible for your co-payment, co-insurance, **and/or** deductible at the time of service. **Please understand that all co-payments are due at the time of service.** It is important for you to be an informed consumer who understands the specifications of your insurance policy regarding doctor visits coverage, referral/authorization requirements for specialty care in allergy, asthma and sinus center. You should refer to information from your insurance company or call them if you have questions about your coverage.

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY- All services performed in our office will be submitted as a courtesy to your insurance. All insurance carriers have a fee schedule from which they will reimburse. Not all services provided by this office are covered benefits in all contracts. Therefore, any balance not covered by insurance becomes the responsibility of the patient/guardian.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY- We are not able to bill your insurance and we cannot accept payment from them for the services performed. You will be classified as self-pay and will be provided with a bill.

BILLING- We accept cash, checks, Master Card, Visa, Discover, and Care Credit. **Balances are due within 30 days unless prior arrangements have been made with the billing department. Outstanding balances not paid in full within 90 days of the first billing statement will be forwarded to a collection**

agency. If your account is turned over to a collection agency we will continue to see you on an emergency basis only for the next 30 days. The accompanying patient/guardian is responsible for full payment at the time of service. We realize that temporary financial problems may affect timely payments on your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account. Should your account balance become uncollectible due to bankruptcy, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care. Please call our office if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent you from receiving the care you need when you need it.

MISSED APPOINTMENTS/LATE CANCELLATIONS- Missed appointments represent a cost to us, to you, and other patients who could have been seen in the time set aside for you. **We reserve the right to charge for missed appointments.** For cancellations, a 24 hour notice prior to the appointment is requested. However, we understand that emergencies arise so please call us if you MUST MISS AN APPOINTMENT. **After a third missed appointment in a family within a one year period, the family will be seen for 30 days to allow time to find a physician practice as we may discharge them from the practice due to failed professional relationship.**

FORMS/PRESCRIPTIONS- We require at least 48 hours for all forms to be completed. Please allow-24-48 hours for prescription refills to be completed. **MEDICAL RECORDS-** We will provide a copy of our records on to another provider one time at no cost. **PLEASE NOTE: ONCE RECORDS ARE TRANSFERRED FOR A PATIENT TO ANOTHER OFFICE, WE WILL NO LONGER BE CONSIDERED THE PRIMARY PROVIDER.** In most cases, we will not accept transferred patients back into our care.

REFERRALS- If your insurance plan requires a written referral for you to see a specialist, for procedures, etc.; you must allow at least 3-5 days business days to complete the appropriate form (s) prior to obtaining services. You may have to reschedule your appointment if enough notice is not given to prepare your referral. Only emergency referrals will be completed on the same day. Retroactive referrals cannot be written and will not be honored. In general, we do not agree to a referral for a person we have not been consulted about first.

MINORS- Effective January 1, 2016: to be in accordance with the South Carolina Code of Laws, we will not see children under the age of 16 in the office without being accompanied by a parent/guardian.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ALLERGY, ASTHMA & SINUS CENTER. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT. DATE: _____

PRINT NAME:_____ **SIGNATURE:**_____**EMAIL:**_____

FORM REVISED 01-01-2020