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 you discontinue any drugs containing any form of antihistamine one week priorto 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 theones you would need to discontinue one (1) week before your appointment.

If you find you are unable to meet your confirmed appointment, ***CALL US*** 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 concerns. If you fail to cancel your appointment within one week, you may be given one other chance to schedule again 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 theperson scheduling your appointment. She will discuss information with you that consist 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 (4) office locations which is located on our website at www.allergysc.com so you can call directly to the office location in 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 and asked for the billing department to discuss financial arrangements and learn about our financial policy and arrangements. 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 and you may also speak with our financial advisor in the billing department about making payment arrangements. We also 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 followAASC's appointment cancellation policy and our financial policy. Thank you and if you have any questions, please call us
843-679-9335.

PATIENT INFORMATION

DATE_____

Welcome to our practice!

CHART#_____

EMAIL_____

DOCTOR_____

PATIENT'S NAME (Please print) Marital status Date of Birth Age Sex Race SS #

STREET ADDRESS OR P.O. BOX CITY AND STATE ZIP CODE

HOME PHONE#_____

CELL PHONE# _____

_____ WORK PHONE# _____

PATIENT OR PARENT'S EMPLOYER Occupation {Indicate, if student)

EMPLOYER'S MAILING ADDRESS CITY AND STATE ZIP CODE

E-MAIL ADDRESS DRIVER'S LICENSE

DRUG ALLERGIES, if any

SPOUSE OR PARENT'S NAME (Required for Minors) SS # DATE OF BIRTH

INSURANCE (Primary) POLICY# NAME OF POLICY HOLDER DATE OF BIRTH SS #

INSURANCE (Secondary) POLICY# NAME OF POLICY HOLDER DATE OF BIRTH SS #

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

REFERRED BY PRIMARY CARE DOCTOR 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 and Other insurance company benefits be made either to me or on my behalf to ALLERGY, ASTHMA AND SINUS CENTER, PC for any services furnished me by that party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information 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 or other insurance companies assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare and Other insurance companies as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co Insurance and the deductible are based 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 ensure 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 disclosure of health information about the patient to carry out treatment, payment, or health care operations.

As our patient at Allergy, Asthma and Sinus Center, PC, 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. W 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.

Patient Name:_____Signature:_____Date:_____

CHART#_____

AUTHORIZATION FOR RELEASE OF

INFORMATIONTO FAMILY AND/OR FRIENDS

PATIENT NAME._____**DATE OF BIRTH**_____

Allergy, Asthma and Sinus Center, PC is authorized to release protected health information reference 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 Individual to Whom Information can be Released) Relationship to Patient

_____ _____
(Name of Individual to Whom Information can be Released) Relationship to Patient

Description of Information to be Released:

Financial Information

_ Family Billing Information

_ Information results from tests 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 and 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 the 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 in effect until revoked by the patient or representative signing the authorization.

_____ _____
Signature of Patient or Personal Representative **Date**

CONSENT FOR TREATMENT OF A MINOR

(Without a Parent or Legal Guardian Present)

DATE_____

PATIENT NAME_____ **DATE OF BIRTH**_____

MINORS <u>UNDER AGE 16:</u>

I understand that it is the Policy of Allergy, Asthma and Sinus Center, PC that minors *under the age of 16* are to 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 the patient instead, as stated below:

_____ _____

(Relationship to Patient)

_____ _____

(Relationship to Patient)

_____ _____

(Relationship to Patient)

MINORS <u>AGE 16 OR OLDER:</u>

<u>ALLERGY SHOTS (Consent for Treatment}:</u>

In the event that I am unable to personally accompany my above -named minor child to Allergy, Asthma and Sinus Center, PC for their allergy shots, I give my permission for my child to travel on an unaccompanied basis to the office of Allergy, Asthma and Sinus Center, PC for the allergy shot(s) 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 shot(s).

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 mychild the need to wait 30 minutes in the lobby of the practice after the shot.

_____ _____

Printed Name of Parent /Legal Guardian Signature of Parent/ Legal Guardian

_____ _____

Witness Signature Date

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 specialtycare 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:**_____

Original Date: 01-01-2020 - **Revised:** 10-21-2021

Medication Protocol

Longer Acting Antihistamines

Stay off of these 5-7 days

- Alavert
- AlevePM
- Allegra (Fexofenadine)
- Allegra D (fexofinadine D)
- Astelin(nose spray) Atrohist
- Bromfed
- Bromhist
- Chlor Trimeton
- Claritin (cetirizine)
- D-Allergy
- Doxepin
- Histussin
- Lodrane
- Loratadine (cetirizine)RespaAR
- 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
- SleepNvtol
- 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 yourmedication

Examples:

- Ativan
- Effexor Elavil(Amitriptyline)
- Eliquis
- Pamelor(N ortriptyline)

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

ALLERGY, ASTHMA AND SINUS CENTER, PC

NEW PATIENT CHECKLIST

The following is a checklist of items we will need you to bring to your first visit. If youshould 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 our 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 to learn more about us. We now have available online "Patient Registrations" forms and "Bill Pay" for your convenience.