Health History Form

Patient Name:_____ **Primary care Dr:** _____
Preferred Pharmacy & location_____ **Who is with patient today** (only if under 18) _____

Does patient have any known drug allergies: Yes or No, if yes what are they?_____
Any Food Allergies? Yes or No , if yes what are they?_____

Past Medical History

(Please check the box next to any of the following that patient has been diagnosed with, past and present)

□**Asthma** □ **Frequent Sinus Infections** *(□1-3 a year, □4-6 a year, □monthly)*
□**Eczema** □ **Frequent Ear Infection** *(□ 0-5 in lifetime,□ 5-10,□ too many to count)*
□**Hives** □ **Recurrent Bronchitis** □ **Crohns**
□**Reflux** □ **Hospitalized for IV Antibiotics** □ **Thyroid Disorder**
□ **Celiac Disease** □ **Pneumonia (ever in lifetime)** □**Ulcerative Colitis**
□ **Cancer**_____ □ **Major infections** (□meningitis,□ sepsis, □deep seated abscesses) □ **Liver Disease**
□ **Kidney Disease** □ **Seizure Disorder** □ **Rheumatoid Arthritis**
□ **High Blood Pressure** □ **High Cholesterol** □ **Any autoimmune condition:**_____
□ **IBS**

Surgery History

(Please check the box next to any of the following surgeries that patient has had)

□ **Adenoidectomy** □ **Appendectomy** □ **Thyroid Surgery**
□ **Deviated Septum** □ **Gallbladder (Cholecystectomy)** □ **Bronchoscopy**
□ **Ear tubes** □ **C- section** □ **Colonoscopy**
□ **Sinus Surgery** □ **Hysterectomy** □ **Tonsillectomy**
□ **Organ Transplant** □ **Esophageal Stretching** □ **Other**_____

Family Medical History(children,Siblings, Parents, Grandparents)

Please check any of the following that pertain to family history and if so please specify who was diagnosed

□**Asthma** _____ □ **Frequent Sinus Infections** _____
□**Eczema** _____ □ **Frequent Ear Infection** _____
□**Hives** _____ □ **Recurrent Bronchitis** _____
□**Reflux** _____ □ **Hospitalized for IV Antibiotics** _____
□ **Celiac Disease** _____ □ **Pneumonia (ever in lifetime)** _____
□ **Cancer**_____ □ **Major infections** (meningitis, sepsis, deep seated abscesses) _____
□ **Rheumatoid Arthritis** _____ □**Ulcerative Colitis** _____
□ **IBS** _____ □ **Crohns** _____
□ **Any autoimmune condition**:_____ □ **Thyroid Disorder** _____

Social History:

Up to date on vaccines? □Yes □No
How many siblings does patient have? ____ brothers _____ sisters _____ none
Is patient exposed to smoke or is a smoker? (Please check the ones that are true for patient)
□ Inside the home □Patient is a smoker (If so how many years?) _____
□ Outside the home □ at family members house
□ in the car □ none of the above
What type of pets do you have? □Cats □Dogs □ Birds □Chickens □Horse □Cattle □NONE

What brings patient in today for appointment? (please check)

□Frequent infections □Rash □ Eczema □ Allergic Reaction □Concerns of pollen allergies □ Concerns of food allergies
□ Hives □Asthma □Cough □Other:_____

Current Medications

_____
_____
_____
_____

Acadiana Allergy, Asthma and Immunology Center, LLC

Patient Registration Form (Under 18 years of age)

If you are the legal guardian (not the birth parent) please provide legal documentation for patient's chart

Patient Information:

First Name: _____ Last Name: _____ DOB: ___/___/_____ SSN: ____-_____-_____ Sex: M / F

Mailing Address: _____City: _____ State/ZIP: _____
Primary Care Physician: _____ Referring Physician (if different): _____
Preferred Pharmacy: _____

Contact Information:

Primary Cell Phone: (___) ____-_____ Secondary phone number: (___) ____-_____
Primary Email Address: _____

Mother's Name: _____ DOB: _____ SSN: _____Employer: _____
Father's Name: _____ DOB: _____ SSN: _____Employer: _____

Guarantor (Person financially responsible)

Responsible Party's Name: _____ DOB: ___/___/_____ SSN: ____-_____-_____
Relation to patient: _____ Phone Number: (____) ____-_____
Mailing Address (If different than patient): _____ City: _____ State/Zip: _____

If there is an existing custody order for patient:
Who has custody? _____ Custody papers on file: Yes / No
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No If yes, explain & provide legal papers:_____
_____

INSURANCE INFORMATION

Primary Insurance: _____
Policy Holder Name: _____
Relation to patient: _____
Policy Holder DOB: ___/___/_____ SSN: ____-_____-_____
Member ID#: _____ GRP#_____

Secondary Insurance: _____
Policy Holder Name: _____
Relation to patient: _____
Policy Holder DOB: ___/___/_____ SSN: ____-_____-_____
Member ID#: _____ GRP#_____

Financial Authorization

I hereby authorize the office of Acadiana Allergy, Asthma and Immunology Center to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payor to pay directly to Acadiana Allergy, Asthma and Immunology Center for services rendered. I authorize the use of the signature on all insurance submissions. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

_____ _____ _____
Signature of Parent/Legal Guardian **Relation** **Date**

Acadiana Allergy, Asthma and Immunology Center, LLC

Office Policies

Patient Name: **Date of Birth:**

We are dedicated to providing the best possible care for your child, and we want to make sure you completely understand our office policies. If you have any concerns, please feel free to ask any member of our staff.

Appointments/No Show/Late Cancellations

- If patient is unable to keep their appointment, please contact our office at least **24-48 hours** in advance to allow someone else the opportunity for an appointment.
- If patient's appointment is rescheduled or canceled **within one hour of appointment time** it will count as a **no show.**
- If you are more than **15 minutes late**, we will do our best to accommodate you. However, you may be required to see our physician extender, another physician, or we may have to reschedule the appointment.
- If patient has **3 or more no show** appointments, you may be asked to find another physician to care for you/your child.

A note on patient/non-patient without scheduled appointments:

- We respectfully ask that you refrain from asking your doctor to examine siblings that do not have appointments. This prevents us from properly documenting the visit in the medical record, as well as prevents us from seeing the next scheduled patients on time. If another child/sibling/family member needs to be seen, please call ahead of time to schedule an appointment in order to update that child's information and pull necessary information for the doctors.

Insurance:

- Your insurance card is required at every visit.
- If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service.
- **IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE**. Many insurance plans have "timely filing deadlines." If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.
- Please keep in mind that your insurance is a contract between you and the insurance company. Not all insurances cover all procedures.
- Please be mindful insurance verification is not a guarantee of payment and ultimately insurance companies have the final say regarding all coverage decisions.

Financial Policy:

- Most major insurance plans are accepted and filed as a courtesy to our patients.
- Any co-pays, deductibles, co-insurance payments, or non-covered services are your responsibility and are due at the time of service.
- We accept cash, debit cards, Visa, Mastercard and discover credit cards & personal checks.
- Patients are responsible for all fees associated with non-sufficient funds (NSF). Returned checks (NSF) will be charged back to the patients account with an additional service fee of $25.00.
- Any outstanding balances are **due within 30 days of the statement**. If you experience circumstances beyond your control, please contact our billing office and we will make payment arrangements.
- All balances reaching **3 months with no payment will go into collections** and **no further appointments will be made** until balance is paid in full.

Divorce Decree:

- We are not a part of your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

Forms and Medical Records:

- Patients are entitled to their medical records. AAAI will comply with the recommended cost of copying records provided by Louisiana state law.
- The form fee for **school, camp, or sport forms** to be completed is $10 charge per form if forms are not filled out during an office visit. FMLA, disability, etc. forms are **$25**. Payment is due when the forms are dropped off. We require **48-72 hours** to complete the forms.
- Any request for a letter describing the diagnosis/treatment/medical care provided by AAAI will require 7 business days to complete and will be at a fee of **$25-50** based on the detail of the request letter. Letters must be paid before they are provided to requester.

Termination from our Practice:

- We value our patient relationships and want to protect patient's rights. We will terminate after careful consideration for reasons of too many no-show appointments; not complying with medical care; being hostile or **abusive to ANY** staff member or not paying your bills.

Acknowledgement

*I have read and understand the above policies of Acadiana Allergy, Asthma and Immunology Center. I agree to the policies above and understand that I am financially responsible for all charges whether or not covered by insurance.

_____	_____	_____
Signature of Patient/Parent/Legal Guardian	**Relation**	**Date**

Acadiana Allergy, Asthma and Immunology Center, LLC

HIPAA Acknowledgement and Designation Disclosure Form(Under 18 years of age)

Patient Name: _____ **Date of Birth:** _____

Acknowledgement of Practice's Privacy Practices:

Acadiana Allergy, Asthma and Immunology Center reserves the right to modify the privacy practices outlines in their notice. I have had the opportunity to read this notice either on their web site www.lafayetteallergies.com or in the office. I consent to the uses and disclosures of the patient's protected health information as outlines in the Notice.

_____ _____ _____

Signature of Parent/Legal Guardian **Relation** **Date**

Release of Information/Consent For Care and Treatment of a Minor

Under the requirements of HIPAA we are not allowed to release medical and/or billing information (with some specific exceptions) without the parent or legal guardian's consent. Any patient under the age of 18 will not be seen without a parent, legal guardian or another authorized representative present(Authorized representative consent must be filled out).

☐ By checking this box**, I do not authorize** Acadiana Allergy, Asthma and Immunology Center to release any of my child's medical and/or billing information, or to bring my child in by anyone other than parents/legal guardian.

Authorized Representatives:

☐By checking this box, I authorize Acadiana Allergy, Asthma and Immunology Center to release my child's medical and/or billing information to the following individuals. I consent for the following individuals to also have permission to accompany my child to their appointment in my absence. I authorize the staff of AAAI to treat the my child for an office visit and or shots without my presence.

1. _____ Relation to patient:_____ Phone Number: _____
2. _____ Relation to patient:_____ Phone Number:_____
3. _____ Relation to patient: _____Phone Number:_____

_____ _____ _____

Signature of Parent/Legal Guardian **Relation** **Date**

Communication:

Patients in our practice may be contacted via email, cell phones and/or text messaging to remind you of an appointment, provide healthcare reminders/information and for patient account information. I understand that it may be necessary from time to time for Acadiana Allergy, Asthma and Immunology Center to leave messages when we are unable to reach you.

☐ By checking this box, **I do not authorize** AAAI Center to leave detailed messages, only authorize them to leave a message with confirmation of appointment or call back only.

☐ By checking this box, I authorize AAAI Center to leave detailed messages at my cell phone number and any other number, or email that I provided to receive communication.

Email:

☐ By checking this box, I give permission to email personal health information (PHI) to the email address that I provided. I understand that there is no encryption guarantee and the information may not be sent over a secure line.

☐ By checking this box, I **do not** give permission to email personal health information (PHI) to the email address that I provided.

ePrescription History Consent:

Our office utilizes ePrescriptions to reduce medication errors and enhance patient safety. One optional feature of this service is the ability to obtain your list of medications from your pharmacy benefit manager using the SureScripts service.

- I authorize Acadiana Allergy, Asthma and Immunology Center to view my child's external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here.

☐By checking this box Parent/Guardian **declines** ePrescription history

Research:

We perform medical research at Acadiana Allergy, Asthma and Immunology Center and may work with drug companies or Academic Centers to help improve care for allergies and immunology. Our clinical research may look at your health records and compile data as part of your current care or to prepare or perform research. All patient research conducted by us goes through a special process required by law that review protections for patients involved in research, including privacy.

☐By checking the box, I prefer **NOT** to be contacted or participate in our clinical research team**.**

Acknowledgement:

I have read the HIPPA Acknowledgement and Designation of Disclosure in its entirety and agree to be bound by all terms and conditions herein. I understand I have the right to revoke authorization, in writing, at any time and that I have a right to inspect or copy my protected health information to be disclosed.

_____ _____ _____

Signature of Parent/Legal Guardian **Relation** **Date**