PATIENT REGISTRATION

Chart No_____

Patient Name _____ Nickname _____

Patient Address _____

City _____ State _____ Zip_____

Home Phone (____)_____ Birthdate _____ Age _____ Sex: ☐ M ☐ F

Father's Name_____ Employer _____

Work Phone (_____)_____ Social Security No. (SSN) _____

Cell Phone (_____)_____ Email _____

Mother's Name_____Employer_____

Work Phone (_____)_____ Social Security No. _____

Cell Phone (_____)_____ Email _____

Referred By: 1.Insurance List; 2.Yellow Pages; 3.Friend/Family; Who: _____

4.Physician; Who: _____

Family Members That Are Patients Here_____

Today's Date:_____

INSURED PERSON OR GUARANTOR (IF NOT PATIENT)

Insured's Name_____ Insured's Date of Birth_____

Insured's Address _____ Insured's SSN _____

City _____ State _____ Zip _____

Home Phone (____)_____ Work Phone (____)_____

Employer _____

Do you have a prescription drug plan? _____ If yes, Name of Plan _____

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

I hereby authorize Metroplex Allergy and Asthma Associates, PLLC. to apply for benefits on my behalf for services rendered by Dr. Ginchansky, Dr. Reddy, Dr. Min or their order. I request that payment from my insurance company be made directly to the doctor.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date_____ Signature_____

(Parent or Guardian)

ALLERGY AND ASTHMA ASSOCIATES

ELLIOT J. GINCHANSKY, M.D. SANDEEP G. REDDY, M.D. DOUGLAS D. MIN, M.D.
7777 FOREST LANE, SUITE C-530 • DALLAS, TX 75230 • (972) 566-7576 • FAX (972) 566-6177

PATIENT QUESTIONNAIRE

Name: _____Gender: _____ Date: _____ Age: _____
Your name & relationship to the patient:_____ DOB: _____
Primary Care Physician: _____

1. Please describe what brings you to Allergy and Asthma Associates:

_____
_____
_____
_____

How long have the symptoms been present? _____

2. Please <u>circle</u> any of the allergy-related problems that are being experienced:

NOSE	EYES	EARS	MOUTH/THROAT	CHEST	SKIN
Itching	itching/burning	itching	sore	cough	itching
sneezing	watering	fullness	itching	trouble breathing	hives
stuffiness	swelling	popping	swelling	wheezing/tightness	rash
runny nose	redness	hearing loss	post-nasal drip	sputum	eczema

3. Symptoms or problems are: ( ) same all year round ( ) worse in the circled months:
Jul Aug Sept Oct Nov Dec Jan Feb Mar Apr May Jun

4. Please <u>circle</u> any of the following things that make the symptoms worse.

Stress	Exercise	Infections (colds, etc.)
Heat / Cold	Odors	Weather Changes

5. Please list any other suspected triggers for the symptoms:

_____
_____

6. How long has the patient lived in Texas? _____years/months
Has the patient had allergy testing? ( ) Yes ( ) No If Yes, when? _____ Where? _____
Type of allergy testing: ( ) skin ( ) blood
Previously been on allergy shots or drops? ( )Yes ( ) No If Yes, when?_____
Other tests previously done: ( ) CT scan, chest or sinus ( ) X-ray, chest or sinus ( ) Breathing tests

7. Has the patient ever had a serious reaction to an insect sting or bite? ( ) Yes ( ) No
If Yes, when and please describe it: _____
Treatment received: _____

8. Treatment/Medications:

List **CURRENT** prescription, "over the counter" or herbal medications being taken for <u>allergies, asthma, hives or eczema</u>, including those stopped in preparation for this visit: (inhalers, nose sprays, nasal/sinus irrigation rinses, drops, tablets, topical medications including creams and ointments etc.).

Medication Name Dosage Is the Medication Effective? Side Effects

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

List **PAST** prescription or "over the counter" medications tried for allergies, asthma, hives or eczema**:**

_____
_____

List **CURRENT** medications being taken for **all other medical conditions** (include dosages if known, also include herbal or health store products). Please bring in typed list of medications if very long.

_____
_____
_____
_____
_____
_____

9. **Reactions to medications. Please list all medications, prescribed or over the counter, which have caused adverse reactions:**

10. Other medical issues (high blood pressure, thyroid disease, diabetes, heart disease, acid reflux, etc.):

_____
_____
_____
_____

Hospitalizations or Operations:

_____
_____

CHILDREN ONLY: Birth History: Birth weight _____ Premature? (if yes, how early) _____
Complications after delivery?_____ Feeding problems?_____

Is the patient fully vaccinated? ( ) Yes ( ) No Received "pneumonia vaccine"? ( ) Yes ( ) No

11. Family History: Are there **nasal allergies, sinus problems, asthma or eczema in any family members?**:
Brothers or sisters (list)_____
Parents or grandparents (list) _____
Are there other medical issues that seem to run in the family?

_____
_____

12. Social History:
Daycare: (circle) In-home Large facility Not Applicable
School: Grade_____ Are there any issues in school?_____
Occupation: _____
Hobbies: _____
Current or past tobacco use, and if so how much and for how long? _____
Current or past secondary smoke exposure?( ) Yes ( ) No

13. Environment and exposures:
Type of Home (please circle): House Apartment Trailer Foundation (please circle): Slab Pier&Beam
Other indoor exposures (please circle): Carpet Stuffed Toys Musty/Moldy Odor
Number of indoor pets: Cats_____ Dogs_____ Birds_____ Other _____
Are pets allowed in patient's bedroom? ( ) Yes ( ) No

14. Review of Systems (Please circle all that apply):
General Health: poor growth, weight loss, weight gain, appetite loss, fevers, poor sleep, frequent infections
Skin: excessive itch, easy bruising, rash
Ears, nose, throat: ear pain, ear infections, hearing loss, nose bleeds, sore throat, hoarse voice, snoring, sinus discomfort, sinus infections, difficulty smelling, difficulty tasting food, difficulty swallowing food
Heart: heart murmur, palpitations, chest pain, lower extremity swelling
Lungs: trouble breathing, wheezing, cough, bronchitis, pneumonia, croup
Gastrointestinal: abdominal pain, vomiting, diarrhea, constipation, vomiting, eating difficulties
Kidney/urinary: pain with urination, blood in urine, frequent urination
Muscles, Bones or Joints: joint pain, joint swelling, broken bones
Nervous System: frequent headaches, seizures, delay in reaching developmental milestones
Mental Health: anxiety, depression, excessive "worry"

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Notice of Privacy Practices Patient Acknowledgement

I,_____, understand that as part of my healthcare, **Metroplex Allergy and Asthma Associates, PLLC** ("Practice") originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality of healthcare.

The Practice's ***Notice of Privacy Practices*** provides specific information and description of how my personal health information (PHI) may be used and disclosed. I have been offered access to or provided a copy of the ***Notice of Privacy Practices*** and understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change the ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time to obtain a current copy. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations. I also understand that the Practice is not required to agree to the restrictions requested, but if you do agree then you are bound to abide by such restrictions. I understand the Practice cannot discuss or disclose PHI with any individual other than myself without designating them by name and relationship in the space provided below.

❑ I request the following restrictions.
_____
_____
_____
_____
_____

❑ I authorize you to discuss my personal health information with the following individuals:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been offered access to, or provided with a copy and have reviewed the Practice's ***Notice of Privacy Practices*** dated January 1, 2018

_____
Patient Name

_____/_____
Signature of Patient or Legal Representative Date

_____
Print Name of Patient or Legal Representative

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices

Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason:

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INFORMATION ABOUT OUR PRACTICE

In an effort to provide our patients with the best possible care and service, we have prepared this information to assist you.

Your first visit

We have scheduled an hour for your first consultation with the doctor. Your visit will consist of an extensive history and physical examination. At this visit, recommendations will be made for future treatment and/or testing. *Due to the nature of our practice, we give our patients the utmost in care and service. Please excuse any delay. We will give you the same careful attention as soon as possible*. Should you require allergy testing, a separate visit will be scheduled. Your testing appointment will take approximately 2 to 2 ½ hours. At the time you are scheduled, you will receive instructions to follow prior to your testing visit.

Treatment of Minors

To provide the most effective medical care, any patient under the age of 18, must be accompanied by a parent or legal guardian. This practice ensures that our physicians are able to obtain the most complete and up-to-date medical information including, but not limited to, current symptoms, medications, and current environment and activities. Please be prepared to be present with your children at each doctor's visit.

Insurance Billing and Financial Policies

Payment for services is *due at the time of service.* We accept cash, checks, Mastercard, Visa, and American Express.

If you are a member of an insurance plan in which we are a participating provider, we will file your insurance. Any co-payments or deductible will be *due at the time of service*. (*Note: If you have a change of insurance, please provide a front and back copy of your new card immediately, so that we can process your claims correctly.)*

For our HMO Patients

Every HMO handles follow-up referrals differently; therefore, our front office personnel will be happy to give you the necessary information for you to secure any future referrals required for services at our office.

Services Rendered

Our practice is limited to the diagnosis and comprehensive treatment of allergy and asthma in children and adults. Should you or your child have problems that fall outside our specialty, these should be cared for by your family physician or appropriate specialist. If you have need for a family physician and don't have one, we will gladly assist you in locating one.

Hours of Operation

Monday, Tuesday, Thursday, & Friday	8:30 a.m. – 5:00 p.m.
Wednesday	Office closed

Injection Room Hours

Monday, Thursday, & Friday	8:30 a.m. – 12:00 p.m.; 1:00 p.m. – 4:30 p.m.
Tuesday	8:30 a.m. – 12:00 p.m.; 1:00 p.m. – 6:00 p.m.
Every other Saturday (see schedule)	8:30 a.m. – 11:30 a.m.

OUR AUTOMATED PHONE SYSTEM

We have installed a voice-mail system to better service our patients. Although we know that these "automated systems" are sometimes frustrating, we have worked very diligently to make simple menu selections to avoid your hold times and to assist you in speaking with the correct person(s) or department.

Please keep this information for your future use. As always, we welcome your comments and suggestions. We are continually striving to offer the best quality and professional medical care.

Office Number (972) 566-7576

VOICE MAIL SYSTEM: *There are six(6) main options to assist you:*

Select (1) If you are a doctor, or need *to speak with a nurse*. You will be immediately transferred to one of our front-line personnel who will obtain your chart for one of our nurses.

Select (2) If you wish to schedule a **routine** appointment, confirm or cancel your appointment, and for medical records. (If you or your family member is ill today, this option should **not** be chosen. Please select option 1, so your concerns can be expeditiously assessed).

Select (3) For any prescription refill(s).

Select (4) For insurance, referral, billing questions.

Select (5) To reorder allergy serum.

Select (6) For directions, fax #, and hours of operation.

Additionally, we have designed our system so that you may use it after hours and on weekends to leave messages with each department. Your calls will be returned when the office reopens.

Prescription Refills

Prescription refills are accepted during the hours of 8:30 a.m. – 4:00 p.m. Monday, Tuesday, Thursday, & Friday. Requests will be filled by the end of the business day.
Please have your pharmacist contact us directly should you require authorization for medication refills.

Emergencies

Our regular office phone number (972) 566-7576 will be answered 24 hours a day. During office hours, we will be available to assist you immediately. After-hour emergencies will be handled initially by our answering service who will then contact the doctor within a few minutes. Our office is closed on Wednesdays, therefore, your call will be answered initially by our voice mail with instructions for emergencies. In rare instances, there are communication delays. Should there be a dire emergency in this situation, please proceed to the hospital emergency room and have them contact Dr. Ginchansky. After-hour calls for prescription refills should not be considered emergency calls.

Medical Calls and Questions

We have staffed our office with experienced nurses who will be available to assist you in receiving prompt attention to your medical questions and illnesses. One of our nurses will confer with your doctor and communicate the appropriate information or treatment plan to you. Please contact our office early in the day as we have set aside a certain number of appointments in the event it is necessary for you to see the doctor.

Medical Records

Should you require a transfer or copy of medical records to be sent from our office, we require a 30-day written notification. Our office will provide a form for this purpose.

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FINANCIAL POLICY

Our Practice Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as essential.

Unless other arrangements have been made in advance, by either yourself or your health insurance carrier, **full payment is due at the time of service.** For your convenience we will accept VISA, Mastercard, American Express, and Discover Card.

Your Insurance

We have made prior arrangements with many insurance carriers of managed care health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized copayment and/or deductible at the time of service. It is the policy of the office to collect the copayment at the time of service. If your plan has a deductible that has not been met, full payment is due at the time of service. Your deductible will be verified on the day of your visit.

If you have insurance coverage with a plan which we do not have a prior agreement, we will provide you with the necessary paperwork of charges for our services for you to attach to your insurance claim form to receive your reimbursement. The charges for your care and treatment are due and payable at the time of service.

In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Allergy Injection Patients

We require our injection patients to clear their balance each month. If we are billing our insurance carrier, we require that you clear any portion owed by you. Our monthly billing cycle ends on the last day of each month, therefore, we request that your balance be cleared with our front office prior to that date.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and received a copy of the financial policy of the practice.

_____ _____

Signature of Patient or Responsible Party Date

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PHARMACY INFORMATION

Patient Name: _____ DOB: _____

It is essential that you provide us with accurate and detailed information about your mail order and local pharmacy. If you are unsure of the address of your local pharmacy, please call your pharmacy before the end of your appointment, complete this form and return it to the front office, or the nurse. If the information is inaccurate, your prescriptions and/or refills will be delayed.

90-day/Mail Order:

- ❑ Aetna Rx Home Delivery ❑ Caremark Mail Order ❑ Express Scripts ❑ Medco Mail Order
- ❑ PharmaCare ❑ Prescription Solutions ❑ PrimeTherapeutics ❑ Walgreens Mail Service
- ❑ Wellpoint NextRx Mail
- ❑ Other _____

Local Pharmacy for 30 day Prescriptions and/or antibiotics:

Name of Pharmacy: _____

Address: _____

_____

Phone Number: _____

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APPOINTMENTS, CANCELLATIONS, AND "BROKEN APPOINTMENT" POLICY

To schedule, confirm, or cancel an appointment, call our office at 972-566-7576 and select option number 2. The appointment line is answered from 8:30 a.m. until 4:30 p.m. Monday, Tuesday, Thursday, and Friday. For your convenience, when the office is closed on Wednesdays, we have an automated voicemail system that will be checked periodically during the day. When leaving a voicemail message, please speak clearly and slowly state your name, spell your last name, state the reason for your call, and leave a phone number where you can be reached.

Office Appointment Hours
Monday, Tuesday, Thursday, and Friday
8:30 a.m. – 5:00 p.m.
Wednesday
8:30 a.m. – 12:00 p.m.
We are closed between 12:00 noon and 1:00 p.m. for lunch
A CANCELLED APPOINTMENT HURTS THREE PEOPLE:
You, Your Doctor and another patient who needed the time for treatment.
Please don't take your appointment lightly. We value your time and appreciate your consideration of ours.

PLEASE LET US KNOW IF YOU CAN'T SHOW!

When you have to cancel, we ask for the courtesy of at least 24 hours advance notice or the last business day before your scheduled appointment if around a weekend or Holiday, so we may offer your time slot to another patient. Because some of our patients do not keep their appointments or do not give adequate cancellation notice, we must enforce the following policy.

It will be counted as a "Broken Appointment" if:

- **you do not keep your appointment;**
- **you do not give at least 24 hours notice when canceling an appointment;**
- **you have an urgent/work-in appointment (given the same day you call) and you do not show or you cancel that visit; or**
- **you receive an automated reminder call and fail to either confirm or cancel as instructed in the message**

If you do not show for your appointment(s) you may be required to pay a $30.00 fee, due before making your next appointment. If you continue to break appointments, you may be given 30 days notice and asked to leave the Practice. **Note:** *Your insurance company does not cover broken appointment charges.*

If you do not call our office to confirm after receiving a reminder call from us, you may be taken off the schedule and your appointment slot may be offered to another patient. Patients who have not confirmed their appointment with our office who then show up for that appointment may be turned away, or asked to make an appointment for a future date.

This policy was created for the benefit of all our patients; we want to assure that those patients in need of our attention will be able to receive it in a timely manner.