



You are scheduled to see _____ at _____ on _____

Location: North Area East Cooper West Ashley Moncks Corner

(First)	(Middle Initial)	(Last)
Date of Birth:	Age:	Sex:
Address:		City: State: Zip:
Home Phone #:	Work Phone #:	Cell #:
S.S.#:	Driver's License #:	Marital Status:
Race:	Ethnicity:	Language:
Email Address :		
Employed By :		
Address :		
Spouse/Parent:	Driver's License #:	
D.O.B.:	S.S. #:	
Employed by:		Work Phone:
Primary Care Physician:		Phone:
Referring Doctor:		Phone:
Pharmacy Name, Address and Telephone Number:		

Ned T. Rupp, MD
 Patricia S. Gerber, MD
 John T. Ramey, MD
 Sangeeta J. Jain, MD

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 7555 Northside Dr.,
 N. Charleston, SC
 29420
 (843) 797-8162
 (fax) 797-8372

Moncks Corner Office
 730 Stony Landing Rd.
 Ste 200
 Moncks Corner, SC 29461
 (843) 797-8162
 (fax) 797-8372

East Cooper Office
 900 Bowman Rd.
 Ste 201
 Mt. Pleasant, SC 29464
 (843) 971-0139
 (fax) 971-0141

West Ashley Office
 1470 Tobias Gadson
 Blvd. Ste. 204
 Charleston, SC 29407
 (843) 573-9373
 (fax) 573-9970

PRIMARY INSURANCE INFORMATION	
Ins. Company Name:	Effective Date:
Insured:	Insured's SS #:
Insured Address:	
Insured Phone #:	Insured D. O. B.:
Policy No:	Group No:
SECONDARY INSURANCE INFORMATION	
Ins. Company Name:	Effective Date:
Insured:	Insured's SS#:
Insured Address:	
Insured Phone #:	Insured D. O. B.:
Policy No:	Group No:

I authorize the release of any medical information necessary to process any insurance claims and access to Pharmacy records. I also authorize payments of medical benefits NATIONAL ALLERGY & ASTHMA. I understand that I am financially responsible for all charges not covered by my insurance, irrespective of the amount of insurance coverage. I understand that my insurance coverage may not cover all of my medical charges, and that I am responsible for any and all billing and/or collection fees.

Signature of Patient or Responsible Party (if a minor)

Date

Signature of Witness

Date

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Briefly state the reason for your allergy consultation: _____

Symptoms: Please check if you have any of the following problems:

- Asthma Food Allergy Hay Fever Hives Headaches Heartburn
 Recurrent infection Sinus Problems Skin Allergy Reaction to insect Eye Allergies
 Other-Describe: _____

Current medications (include doses): _____

List all your medical diagnoses: _____

Describe any reactions to medications or latex: _____

Describe any SEVERE reactions to bees, wasps or fire ant: _____

Describe any food allergies: _____

Surgery (type and age when occurred): _____

Past hospitalizations/ER visits for allergies or asthma: _____

Family History (allergies/asthma/eczema): _____

Have you ever smoked? _____ How many years have you smoked? _____

How many packs per day have you averaged? _____

Have you quit smoking? _____ If no, are you ready to stop smoking? _____

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PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. We want to work with you to manage the financial responsibilities you incur as our patient. The following information explains our financial policy:

- Unless other arrangements have been made in advance by either you or your health coverage carrier, **full payment is due at the time of service.** For your convenience, we will accept VISA, Mastercard, American Express, Discover or debit card.
- Your insurance policy is a contract between you and your insurance company; the doctor is not involved. Failure to supply our office with current insurance cards and personal information may result in you being responsible for the visit and/or fees **We cannot waive any co-pay, co-insurance or deductible due to healthcare fraud laws.**
- As a courtesy, we will file your insurance claim for you if you assign the benefits to the physician. In other words, you agree to have your insurance company pay the physician directly. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We can bill those plans with whom we have an agreement and can only require you to pay the authorized co-payment at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
- Our practice provides several types of allergy testing and allergy shots. Each health insurance policy reimburses differently for these services. In order to verify your personal plans' reimbursement, you will need to contact your insurance company and reference the below CPT codes:

Insect/Drug Testing: 95010, 95015 • Immunotherapy: 95117, 95165
 Allergy Testing: 95004, 95024 • Insect Immunotherapy: 95170 • Patch Testing: 95044

By signing this agreement, you understand the amount of coverage provided by your insurance for these services and agree to cover the remaining balance.

- All health plans are not the same and do not cover the same services. 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.
- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- 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.
- In order to provide the best possible service and availability to all our patients, please call at least 24 hours prior to your appointment if you know you will need to reschedule your appointment. There will be a \$50 charge if the appointment is not cancelled in the appropriate amount of time or if the patient is a “no show”.
- We charge \$35.00 for checks returned for insufficient funds.
- If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment to insure we have received the referral. It is also your responsibility to keep track of your authorization and make sure you have one each time you see the doctor to receive allergy injections. If the referral is not in hand at the time of service the appointment must be rescheduled.
- We require a physician visit to complete any forms for school, work, etc.
- Your physician may require an office visit in order to process a prior authorization for medication.
- At the physician's discretion, a physician may bill for a “physician to patient” phone call.
- If payment is not made within a timely manner you will be referred to an outside collection agency. You will be responsible for all reasonable collection fees.
- You agree, in order for us to service our account or to collect any amounts you may owe, we as well as our third party debt collector may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We as well as our third party debt collector may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
- I agree that I will be responsible for all attorney costs and court fees required to settle my account. This agreement is governed by the laws of the SC.
- ***I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to-time by the practice. If you have any questions about the policy, please discuss them with our Administrator.***

By signing, you understand you will be responsible for any remaining balance.

Signature of Patient or Responsible Party (if a minor): _____ Date: _____

Signature of Co-Responsible Party: _____ Date: _____

Printed Name of Patient: _____

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Consent for Medical Treatment:

I voluntarily consent to medical treatment and diagnostic procedures provided by National Allergy & Asthma and its associated physicians, clinicians and other personnel. I consent to the testing for infectious diseases. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I have read or have had read to me this consent and understand and agree to its contents.

Initials

Authorization for Release of Information and Assignment of Insurance Benefits:

My physician is authorized to release any medical information required in the processing of applications and submission of information for financial coverage. I also agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries - I provided all necessary information for proper assignment of Medicare/Medicaid benefits.

Initials

Agreement of Financial Responsibility:

I guarantee payment of all charges associated with services received from National Allergy & Asthma. I agree to assign any insurance benefits or other funding to National Allergy & Asthma. I understand it is my responsibility to verify participation status of the physician with my health plan prior to the patient's visit and to obtain all authorization as required by my health plan prior to the patient's visit.

Initials

H.I.P.A.A. (Health Insurance Portability and Accountability Act) Notification:

I acknowledge my receipt of a copy of the National Allergy & Asthma's Notice of Privacy Practices.

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility can only be revoked upon written notice. By signing below, I acknowledge that this consent form has been read in full and explained as necessary.

I authorize National Allergy & Asthma physician's and staff to contact me via mail, by phone, or cell phone. If I am unavailable, the physicians or staff may leave messages for me with person or machine at the phone number I have provided.

Initials

Date and Time

Signature of Patient (Parent or Legal Guardian)

Signature of Witness

Signature of Guarantor (if different from the patient)

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NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this notice of Privacy Practices. This Notice will take effect on March 26, 2013 and will remain in effect until it is amended or replaced by us. We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and /or received by us before the date changes were made. You may request a copy of our privacy Notice at any time by contacting our Privacy officer, Amber Murphy.

Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, Business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by federal law to protect your health information. We have established “minimum necessary” or “need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so, as of march 26, 2003 immunization records for students may be released without an authorizations (as long as the PHI disclosed is limited to proof of immunizations). If an individual is deceased you may disclose PHI to a written authorization. Genetic information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act.

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allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$0.65 for each page and the staff time charged will be \$15. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: if you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, the Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of an emergency involving your care, your location, your general condition or death. If at all possible we will provide you the opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/ or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/ infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and

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treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). “Sale of PHI” does not include disclosures for Public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is “a reasonable cost-based fee” to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of “sale”.

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) we will provide access to health information in a form/format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested will be \$0.65 for each page and the staff time charged will be \$15. If you want the Copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: it is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any others steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

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I, _____, do hereby authorize a representative from National Allergy & Asthma to speak with the following person(s) regarding my: **(please check all the apply)**

Name	Relationship	Phone Number	Medical Care	Appointments
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Do you give the above representative(s) authorization to the following information:

I do I do **NOT** Authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), sexually transmitted diseases, psychiatric care, psychological assessment and treatment for alcohol and / or drug abuse.

I do NOT wish for any medical information/appointments to be released to any representative on my behalf.

I do I do **NOT** Authorize National Allergy & Asthma to communicate my protected health information or billing information to me via voicemail.

Signature of Patient or Responsible Party (if a minor)

Date

Signature of Patient of Witness

Date

This form will be valid until patient rescinds authorization in writing.

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Please contact your prescribing physician before stopping any of the following medications

Certain medications such as antihistamines may interfere with allergy skin testing, which we may perform. Most cough and cold medications contain antihistamines. One tablet, one capsule or one teaspoon of antihistamine may neutralize the skin tests so that they cannot be read properly.

If you need temporary relief of allergy symptoms prior to being tested, Sudafed (not Actifed or Sudafed Plus), Nasalcrom, Phenylephrine, Robitussin DM or Pseudoephedrine can be taken. If you have a fever or are wheezing or pregnant, please let us know because skin testing should not be performed.

Since it is not possible to list all of the antihistamines, please call our office or your pharmacist if you have a question. Products classified as anti-nausea, anti-depressants, tranquilizers, anti-anxiety and motion sickness medications may also contain antihistamines and should not be taken 48 HOURS BEFORE TESTING. PLEASE AVOID THE FOLLOWING MEDICINES FOR 5 DAYS PRIOR TO YOUR APPOINTMENT:

AccuHist Products	Clarinox	Hycomine	Ranitidine
Alavert	Claritin	Hydroxyzine	Remeron
Aleve products (some)	Clemastine	Imipramine	Restaril
Alka- Seltzer	Clomipramine	Levocetirizine	Sinequan
Allegra (Fexofenadine)	Cyproheptadine	Lodrane	OTC cough/cold
Amitriptyline	Dayquil	Loratadine	Sudafed-Plus
Antivert	Desipramine	Meclizine	Sudafed Sinus/Allergy
Astelin Nasal Spray	Desloratadine	Mesclor	Tagamet
Astepro	Dimetane Products	Mirtazapine	Tavist Products
Atarax	Dimetapp Products	Nortriptyline	Temazepam
Axid	Diphenhydramine	Nyquil Products	Triaminic Products
Azelastine	Doxepin	Optivar eye drops	Tussi-12
Benadryl	Dramamine	Pataday	Tussionex Products
Brompheniramine	Dristan Products	Patanase	Tylenol Products
Carbinoxamine	Dymista	Patanol	Vicks Products
Cetirizine	Elavil	Periactin Pepcid	Vistaril
Chlordiazepoxide	Extendryl Products	Phenergan Products	Xyzal
Chloro-Trimeton	Famotidine	Poly- Histine	Zaditor
Clorpheniramine	Fexofenadine	Promethazine	Zantac
Cimetidine	Flurazepam	Pyrilamine (Midol Complete only)	Zyrtec

If You are on a beta blocker drug, ask your prescribing physician if the drug can be omitted the day before and the day of testing. These drugs are usually taken for high blood pressure, migraine headaches, or heart problems. **NO BETA THE DAY BEFORE AND THE DAY OF THE TESTING.** The following are beta blockers:

Acebutol	Coreg	Lopressor	Tenoretic
Atenolol	Corgard	Metipranolol	Tenormin
Betagan	Corzide	Metoprolol	Terazosin HCL
Betapace	Esmolol	Nadolol	Timolide
Betaxolol	Hytrin	Normodyne	Timolol
Betaxon	Inderal	Ocupress	Timoptic
Betimol	Inderide	Optipranolol	Tomoptic
Betoptic	Innopran	Oxprenolol	Toprol
Bisoprolol	Istalol	Penbutolol	Trandate
Blocadren	Kerlone	Pindolol	Visken
Brevibloc	Labetalol	Propranolol HCL	Zebeta
Bystolic	Levatol	Sectral	Ziac
Carteolol	Levobetaxolol	Slow-Trasicor	
Cartrol	Levobunolol	Sotalol	
Carvedilol			

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YOU SHOULD CONTINUE THE FOLLOWING MEDICATIONS:

Accolate	Elestat	Orapred	Spiriva
Advair	Flonase	Oxymetazoline	Symbicort
Aerobid	Flovent	Phenylephrine	Theo-24
Afrin	Foradil	Prednisone	Theophylline
Albuterol	Guafinesin	Prednisolone	Tilade
Alupent	Intal	Prelone	Uniphyll
Alvesco	Maxair	Proventil	Ventolin
Asmanex	Medrol	Pseudoephedrine	Xolair
Atrovent	Mucinex	Pulmicort	Xopenex
Azmacort	Nasacort	QVAR	Veramyst
Combivent	Nasalerom	Rhinocort	Volmax
Dulera	Nasalide	Serevent	VoSpire
Duoneb	Nasarel	Singulair	Zyflo
	Nasonex	Solumedrol	

Please Contact your prescribing physician before stopping any of the previous medications. If you are not sure whether you should stop a medicine and it is not on the previous lists, please contact our office to see if the medicine should be continued or discontinued prior to allergy skin testing.

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Have you experienced any of the following in the last 3 months? Please select appropriate **YES** or **NO** by filling out the bubble, please don't mark X on bubble.

	YES	NO
General/Constitutional Fever > 100.5	<input type="radio"/>	<input type="radio"/>
Allergy/Immunology 3 or more treatment of antibiotics	<input type="radio"/>	<input type="radio"/>
Ophthalmologic Loss of Vision	<input type="radio"/>	<input type="radio"/>
ENT Decreased sense of smell	<input type="radio"/>	<input type="radio"/>
Respiratory coughing up blood	<input type="radio"/>	<input type="radio"/>
Cardiovascular Chest pain	<input type="radio"/>	<input type="radio"/>
Gastrointestinal Heartburn more than 2 days a week	<input type="radio"/>	<input type="radio"/>
Hematology Bruises that don't heal	<input type="radio"/>	<input type="radio"/>
Musculoskeletal Swollen joints	<input type="radio"/>	<input type="radio"/>
Skin Dry Skin	<input type="radio"/>	<input type="radio"/>
Past Medical History Have been diagnosed by a physician with	<input type="radio"/> Asthma	<input type="radio"/> Eczema
	<input type="radio"/> COPD	<input type="radio"/> Hay Fever
		<input type="radio"/> Hives

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Family History

Do your parents, Siblings, or Children Have:

<input type="radio"/> Eczema	<input type="radio"/> Nasal Allergies	<input type="radio"/> Asthma
<input type="radio"/> Food Allergy	<input type="radio"/> Immune System Problem	<input type="radio"/> None

Social History

How old is your house? <10 years 10-20 years >20 years

What type of flooring do you have in your bedroom? carpet other

What type of pillow do you use? feather synthetic

Second hand exposure to cigarettes: home work none

Yes **No**

Does your house have history of mold damage?	<input type="radio"/>	<input type="radio"/>
Have you had pneumonia vaccine (pneumovac) in past 5 years?	<input type="radio"/>	<input type="radio"/>
Are your routine immunizations up to date?	<input type="radio"/>	<input type="radio"/>

Exposure on regular basis to pets:

<input type="radio"/> dog	<input type="radio"/> cat	<input type="radio"/> horse
<input type="radio"/> rabbit	<input type="radio"/> gerbil	<input type="radio"/> hamster
<input type="radio"/> guinea pig	<input type="radio"/> birds	<input type="radio"/> none of the above

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