Welcome to Academy Allergy Asthma & Sinus!

Thank you for choosing Academy Allergy Asthma and Sinus, PC. We look forward to providing you with the best medical care for your allergy, asthma and immunology problems. You have put your trust in us to make the best diagnoses and treatment plan for you. In order to do so, we need your help in providing essential information through our registration forms. If you have any questions about our forms or your appointment please call the office. We encourage you to visit our website for more information about our practice and providers.

What to bring to your appointment:

1. **Completed Registration Form and Patient Consent Agreement**
2. **Medication List including Dosage and Frequency**
3. **Insurance Card and a Photo ID**
4. **Appropriate X-Rays and Laboratory Reports**

We also encourage you to confirm your insurance benefits prior to your visit as it is our policy to collect your portion of the cost at the time of service. We have provided some common procedure codes used in our office to assist you in obtaining correct coverage information.

Name of Procedure	CPT Code	Covered by Insurance	Procedure covered by copay or deductible	Amount Patient will be responsible to pay
Office Visit	99204			
Allergy Skin Testing	95004			
Allergy Injections	95117			
Allergy Serum	95165			
Spirometry	94010			

Please arrive at least **15 minutes early** to allow our staff to complete your registration. If you need to cancel your appointment, please give us 24 hours notice so we can offer your appointment time to someone on our waiting list. We also ask that you not wear any perfume or cologne in our office.

Allergy Testing Procedures
Based on your symptoms, we may find it necessary to perform tests such as allergy 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.

In preparation for your exam, please do not take any cold or sinus medications or antihistamines for five days prior to your appointment and the day your appointment do not apply any lotions to your arms if we are doing testing.

Academy Allergy Asthma & Sinus, PC

David L. Patterson, MD   Tracy A. Donahue, CFNP, CPNP

(317) 621.2455

Patient Registration Information

First Name:	Middle Initial:	Last Name:	
SSN:	DOB:	Gender: M F	AKA:
Home Address:		City, State, Zip:	
Home Phone:		Work Phone:	
Cellular Phone:		Preferred Phone: ☐ Home ☐ Work ☐ Cell	
Email:		Accept Texts for Appt. Confirmation? Y N	

Race: ☐ Black/African American ☐ White/Caucasian ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander

Ethnicity: ☐ Hispanic ☐ non-Hispanic

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Pharmacy Name:	Pharmacy Address:
Primary Doctor:	Primary Doctor Phone:
Referring Doctor:	Referring Doctor Phone:

Person Responsible for Payment

☐ Check if patient address

First Name:	Last Name:	
DOB:	SSN:	Gender: M F
Home Address:	City, State, Zip:	
Home Phone:	Work Phone:	
Cell Phone:	Fax:	
E-mail:		

Health Insurance Information

Insurance Name:		
ID Number:	Group Number:	
Insured First Name:	Middle Initial:	Last Name:
DOB:	SSN:	Gender: M F
Relationship to patient:		
Home Address:	☐ Check if patient address	
City, State, Zip:		
Home Phone:	Work Phone:	
Cell Phone:	Fax:	
E-mail		

Emergency Contact

First Name:	Middle Name:	Last Name:
Home Phone	Work Phone:	
Cell Phone:	Relationship to Patient:	

Academy Allergy Asthma & Sinus

Patient Consent Agreement

Patient Name: ____________________________________ Date of Birth: ____________

Thank you for choosing us as your health care provider. We appreciate your confidence and trust.

The following is a statement of our policies that we require you to read and sign prior to treatment.

- I hereby consent to the physician and other persons acting under his direction and supervision to administer examination, treatments and other procedures as are deemed necessary.
- We will prepare and file insurance claims for the services you receive, but we require all co-payments and deductibles to be paid at the time of service, without exception. You are obligated and responsible to pay your portion.
- I understand that I am financially responsible for all amounts not paid by insurance. All balances are due within 30 days of the statement date.
- I hereby authorize the provider to release all information necessary to secure the payment of benefits. I designate Academy Allergy Asthma & Sinus, P.C. and its employees and agents as my representative to file grievances and to represent me with my insurance plan/HMO as allowed by Indiana State Law. I understand this authorization will remain in effect until revoked in writing.
- Even within the same insurance company, the plans may differ depending on what type of contract your employer has negotiated. Therefore, if you do not obtain the preauthorization required in your contract, and we subsequently treat you without the necessary authorization, we will have no choice but to bill you directly for the charges.
- Prescription refill requests are handled during office hours and may take up to 48 hours to process. There will be a $5.00 charge for lost prescriptions.
- There is a $10.00 charge to complete forms for school or insurance. The charge to complete forms for FMLA is $25.00.
- As a service to our patients, we will attempt to make a courtesy appointment reminder call. By providing your cell phone number, you consent to receive such calls at this number.
- Promptness is appreciated for all appointments. <u>We require 24 hours notice if you need to cancel your appointment.</u> (We have voice mail available after hours.) This will allow us time to offer your appointment to another patient. If you arrive fifteen or more minutes late for your appointment you may be asked to reschedule.
- A $45 charge will be assessed if you fail to provide the 24 hours advance notice when canceling or rescheduling an appointment. If three appointments are missed, our professional relationship with you will be terminated and you will be asked to seek treatment from another health care provider. In the event of severe weather, please phone the office for delay or closing information.
- Requests for copies of patient medical records will be subject to a fee as authorized by Indiana Law. If records are to be mailed, there will be an additional postage charge.
- I hereby agree to pay Academy Allergy Asthma & Sinus, P.C. the charges for all medical services rendered. In the event that I fail to pay the fees as agreed, I understand I will be responsible for all attorney fees, court costs and collection fees that may result from my failure to pay.
- I acknowledge receipt of this facility's Notice of Privacy Practices. (Available anytime on-line or in our office.)
- I acknowledge that I have read and agree to this Patient Consent Agreement and my questions have been answered. If I am agreeing and signing on behalf of a minor patient, I affirm that I have the legal right to consent and agree on behalf of that minor. I understand that I can request a copy of this document.

Patient (18 or over) or Legal Guardian Signature: ____________________________________ Date: ____________

Guarantor Signature: ____________________________________ Date: ____________
(Person responsible for payment)