WEXFORD ALLERGY • ASTHMA & IMMUNOLOGY LLC

IMPORTANT: Please complete, sign where indicated, and return ALL enclosed forms, even if you already discussed any of this information with one of our staff.

We are **unable to schedule your appointment until we have received each and every part of this packet**, properly completed and signed as required.

There are 5 different forms in this packet, 14 pages in total, with **4 signature pages**:

- □ New Patient Registration and Medical History (**6 pages completed**)
- □ Acknowledgment of Receipt of Notice of Privacy Practices for Protected Health Information (1 page, reviewed, completed, and **signed**)
- □ Notice of Nondiscrimination and Accessibility Requirements Discrimination is Against the Law (2 pages, reviewed, completed, and **signed**)
- □ Confidential Communication Authorization (1 page, completed and **signed**)
- □ Financial Policies and Procedures (4 pages, reviewed, completed, and **signed**)

Copies of the following also are **required** for scheduling:

- □ **Copy of photo ID** such as driver's license for the patient, or for the parent/legal guardian of the patient
- □ **Copy of front and back of all insurance cards**
- □ **Copy of front and back of prescription card** (if you have one)

I hereby certify that all of the above documents are complete and signed where applicable.

Print patient name _____Print parent/legal guardian name_____

Signature_____

Wexford Allergy, Asthma & Immunology, LLC
100 Bradford Road, Suite 410, Wexford, PA 15090
Phone (724)719-2441 / Fax (724)719-2451
www.wexfordallergy.com

New Patient Registration and Medical History

Name _____ Today's date _____

Address _____ City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Email _____

Birth date _____ Sex M/F Marital status _____ Social security # _____

Occupation & employer/school _____ Race/Ethnicity _____

Referring physician _____ Primary care physician _____

Preferred pharmacy name & phone # _____ Mail order pharmacy _____

What is the reason for your visit today?

If you have been given a diagnosis by another physician, please specify it here, as well as the diagnosis code if known.

PAYMENT AND INSURANCE INFORMATION

Please note that we will need to copy your photo ID and insurance card.

Primary Insurance _____ Member ID# _____

Group name _____ Group/Plan # _____

Policy holder/Subscriber name _____ Relationship to patient _____

Policy holder/Subscriber birth date _____ Phone number _____

Policy holder/Subscriber address _____

Do you have separate pharmacy coverage? Yes / No If yes, please provide the ID # _____

Secondary Insurance (if applicable) _____ Member ID# _____

Group name _____ Group/Plan # _____

Policy holder/Subscriber name _____ Relationship to patient _____ Birth date _____

Financially responsible party

If the patient is a minor, to whom should bills be sent? Name _____

Relationship to patient _____ Date of birth _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

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Patient name _____

ALLERGY AND ASTHMA HISTORY

Date of birth _____

	Yes	No	If yes, please answer the questions below:
Has the patient ever been diagnosed with asthma?			**At what age?** **Any hospitalizations for asthma? When?** **Any ER visits for asthma? When?** **Any oral steroids (prednisone) for asthma? When?**
Has the patient ever had allergy testing before?			**When?** **By whom?** **Ever on allergy shots?**
Has the patient ever been diagnosed with eczema?			**Evaluated by a dermatologist?**
Has the patient had adverse reactions to foods?			**Please explain.**
Has the patient had adverse reactions to medications?			**Please explain.**
Has the patient had adverse reactions to bee stings?			**Please explain.**
Has the patient had adverse reactions to latex?			**Please explain.**

Patient name _____

PAST MEDICAL HISTORY

Date of birth _____

Is the patient pregnant? Yes No (Please circle your response)

Please indicate if the patient has, or is being treated for, any of the following:

	Yes	No		Yes	No		Yes	No
Cataracts			**Thyroid disease**			**Sleep apnea**		
Glaucoma			**Lupus**			**GERD (heartburn)**		
Osteoporosis			**Rheumatoid arthritis**			**Headache/Migraine**		
Anemia			**Celiac disease**			**Nasal polyps**		
Diabetes			**Psoriasis**			**Sinus infections**		
Heart disease			**Anxiety**			**Ear infections**		
High blood pressure			**Depression**			**Pneumonia**		
High cholesterol			**Cancer (specify type)**			**COPD (emphysema)**		

Does the patient have **any other medical problems**? Please specify.

HOSPITALIZATION HISTORY

Please list **all hospitalizations** the patient has had, with the **year** and the **reason:**

SURGICAL HISTORY

Please indicate if the patient has had **any of the following** procedures, and specify the **year**:

	Yes	No	When		Yes	No	When
Tonsillectomy				**Sinus surgery**			
Adenoidectomy				**Nasal surgery**			
Ear tubes				**Nasal polyp removal**			

Has the patient had **any other surgery**? If yes, please **specify the procedure and year** it was performed.

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FAMILY HISTORY

Date of birth _____

Have any of the patient's **blood relatives** been diagnosed with any of these conditions? If yes, please specify who:

	Yes	No	Who?		Yes	No	Who?
Asthma				**Cataracts**			
Allergic rhinitis/hay fever				**Glaucoma**			
Eczema				**Thyroid disease**			
Food allergies				**Lupus**			
Celiac disease				**Rheumatoid arthritis**			
Urticaria (hives)				**Cancer (type?)**			
Angioedema (swelling)				**Diabetes**			
COPD/Emphysema				**Hypertension**			
Osteoporosis				**High cholesterol**			

MEDICATIONS

Please list the patient's current medications and doses.

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

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Patient name _____

Date of birth _____

ENVIRONMENTAL HISTORY

	Yes	No	If yes, please answer:
Are there any pets in the patient's home, or is there any other exposure to animals?			**What kind, and how many?**
Has the patient ever smoked?			**How much, and for how long?** **Does the patient want to quit?**
Does anyone smoke around the patient?			
Does the patient go to school or daycare (children)?			
What is the patient's occupation?			
Is there anything the patient is exposed to that you believe triggers symptoms? **Any season when they get worse?**			**Please explain.**

IMMUNIZATIONS

If the patient is age 18 years or under, is he/she **up to date on all childhood vaccines?** Yes No

When was the patient's **last flu shot?** Please give the date. _____

Has the patient **ever had a pneumonia vaccine?** Yes No

If yes, which one, and when? Pneumovax date _____ Prevnar date _____

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Patient name _____

Date of birth _____

REVIEW OF SYSTEMS – Is the patient **currently** experiencing any of the following symptoms?

GENERAL ○ Chills ○ Fatigue ○ Fever	**NECK** ○ Lumps	**MUSCULOSKELETAL** ○ Joint stiffness ○ Muscle pain ○ Joint pain ○ Joint swelling ○ Joint redness/warmth
EYES ○ Swelling ○ Watery ○ Itchy ○ Red	**RESPIRATORY** ○ Difficulty breathing ○ Chest tightness ○ Cough ○ Trouble with exercise ○ Wheeze	**SKIN** ○ Flaking/peeling ○ Hives ○ Itching ○ Swelling ○ Rash ○ Redness/flushing
EARS, NOSE, THROAT ○ Itchy ears ○ Sneezing ○ Runny nose ○ Post-nasal drip ○ Itchy nose ○ Stuffy/congested nose ○ Itchy throat ○ Frequent throat clearing ○ Hoarseness ○ Sinus pressure ○ Nosebleeds ○ Ear fullness/popping ○ Loss of sense of smell ○ Ear pain ○ Sore throat	**GASTROINTESTINAL** ○ Stomach pain ○ Constipation ○ Diarrhea ○ Heartburn ○ Nausea ○ Vomiting	**NEUROLOGIC** ○ Dizziness/vertigo ○ Headache **PSYCHIATRIC** ○ Sleep disturbance ○ Stressors

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Wexford Allergy, Asthma & Immunology LLC's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient:_____
Print Name

_____
Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgment

I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that apply):

- ❑ Showing the patient the Notice of Privacy Practices posted in our office.
- ❑ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ❑ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ❑ Asking the patient to sign this Acknowledgment form.
- ❑ Other (explain in detail) _____
  _____
  _____

I was unable to obtain the patient's written Acknowledgment because (check all that apply):

- ❑ The patient refused to sign this form.
- ❑ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ❑ Other (explain in detail) _____
  _____
  _____

Date: _____ Name:_____

Notes: This written Acknowledgment must be completed no later than the first date health care services or treatment is provided to the patient. This Acknowledgment must be retained in the patient's permanent records.

Notice of Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Wexford Allergy, Asthma & Immunology, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Wexford Allergy, Asthma & Immunology, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Wexford Allergy, Asthma & Immunology, LLC provides free, qualified interpreters, to people whose primary language is not English. If you need these services, contact Lori Ubinger at 724-719-2441.

If you believe that Wexford Allergy, Asthma & Immunology, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Lori Ubinger, Office Manager, 100 Bradford Road, Suite 410, Wexford, PA 15090, Phone: 724-719-2441; Fax: 724-719-2451; Email: loriwexfordallergy@gmail.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Lori Ubinger, Office Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

I acknowledge that I have received Wexford Allergy, Asthma & Immunology, LLC's Notice of Nondiscrimination and Accessibility Requirements.

Date: _____ Name of Patient:_____
Print Name

_____
Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgement

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Nondiscrimination and Accessibility Requirements by (check all that apply):

- o Showing the patient the Notice of Nondiscrimination and Accessibility Requirements posted in our office.
- o Giving the patient a copy of our Notice of Nondiscrimination and Accessibility Requirements to read prior to receiving any treatment or service.
- o Giving the patient all necessary information to obtain our Notice of Nondiscrimination and Accessibility Requirements on our website.
- o Asking the patient to sign this Acknowledgement form.
- o Other (Explain in detail)

  _____
  _____
  _____

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- o The patient refused to sign this form
- o The patient would not sign the form because the patient said he/she did not understand the notice.
- o Other (Explain in detail)

  _____
  _____
  _____

Date: _____ Name:_____

Notes: This written Acknowledgment must be completed no later than the first date health care services or treatment is provided to the patient. This Acknowledgment must be retained in the patient's permanent records.

Confidential Communication Authorization

The HIPAA Privacy Act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

Patient Name: _____ Patient Date of Birth _____

Please indicate how you would like the practice to communicate with you (the patient) (check all that apply):

Preferred contact number: _____

May we call your home?

- ❑ Yes ❑ No
- ❑ O.K. to leave message with detailed info.
- ❑ Leave message with call back number only
- ❑ Written communication
- ❑ O.K. to mail to home address
- ❑ O.K. to fax to this number: _____

May we call your cell phone?

- ❑ Yes ❑ No Cell number: _____
- ❑ O.K. to leave message with detailed info.
- ❑ Leave message with call back number only

Whom may we contact in case of emergency and/or leave messages about the patient's care?

Name_____ Relationship to you_____ Phone # _____

Name_____ Relationship to you_____ Phone # _____

Is there anyone you do <u>NOT</u> wish us to communicate with?

_____

_____

What information do you wish us to leave in a message or with someone else?

- ❑ Message with details
- ❑ All information necessary
- ❑ Message only to return call to office
- ❑ Other _____

_____ _____

Signature of Patient or Patient Representative Date

_____

Print Name

WEXFORD ALLERGY • ASTHMA & IMMUNOLOGY LLC

FINANCIAL POLICIES AND PROCEDURES

At Wexford Allergy, Asthma & Immunology, LLC, we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. In order for us to provide you with the highest quality medical care and current technology, we must insure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this Agreement regarding our financial policy and your agreement to pay for services provided. Please sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

Your insurance policy is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. If your insurance carrier does not provide payment within 40-60 days after treatment, you will be responsible for payment. You are responsible for timely payment on your account. We require that you pay any amount not covered by your insurance such as deductibles and copayments under your policy on the day of service. If your plan requires you to pay co-insurance, you will be required to pay that. Wexford Allergy, Asthma & Immunology, LLC, is required in accordance with its contract with your insurer to collect from you deductibles and copayments. We will determine your copay and how much of your yearly deductible under your policy has been met for the year. If you are unable to pay your copayment at check-in, another appointment will be made for you. Any additional payment owed will be collected in full at the time of service. If needed, we will work with you to arrange a payment plan.

It is your responsibility to provide us with your current insurance card and photo identification at every visit so that we may bill the insurance company in a timely fashion. It will be reviewed or copied every time you are here for a visit, no matter how frequently you are seen. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. **Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, what your copay is and what your deductible is.** It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered.

Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your needs.

Once we determine your personal financial obligation or after your insurance company reimburses Wexford Allergy, Asthma & Immunology, LLC, for a portion of your care, we will mail you one (1) statement. Payment is expected upon receipt of the statement. Any account past due by 30 days or more may be subject to submission to our collection agency. If your account becomes delinquent and is placed into our collection process, collection fees will be added to your balance. Wexford Allergy,

Asthma & Immunology, LLC, reserves the right to terminate any patient at this point. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account, including interest charges.

If a new problem is encountered, or if changes in treatment of a pre-existing condition are discussed in the process of performing a visit or exam, an additional copay and deductible payment may be incurred.

If you are seen in our office by a nurse or a medical assistant for minor medical services you may be charged a limited office visit, and applicable co-pays will be collected.

If you carry a balance on your account during the time you present at our office, a payment on your account will be required at the time unless a payment plan is in place. Wexford Allergy, Asthma & Immunology, LLC, reserves the right to terminate any patient who misses a payment. Under unusual circumstances, we are willing to work out personalized payment schedules if you so require and can demonstrate need. We accept cash, check or credit card.

ELECTIVE PROCEDURES

Patients are required to pay the estimated self-pay portion of elective procedures prior to services being rendered.

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

PAYMENT OPTIONS

Our office accepts all credit and debit cards. Our office also accepts check or cash. There will be a $50 fee for all returned checks. Once we have a returned check for you we may require that all future payments be with cash, money order, cashier's check or credit card. We may offer to keep a credit card authorization on file at our office. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit card which will help to keep you at a zero balance and paid up in full.

CASH PAYMENT

If you wish to pay cash, please ask for a receipt so that you will have a record of your payment.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the deductible, copay and co-insurance at the time of service. You are also responsible to pay for services not covered by your Medicare insurance unless you have a secondary insurance. You will be required to sign an Advanced Beneficiary Notice for non-covered services.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may have out-of-network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.

UNINSURED/SELF-PAY

We offer a discount to all self-pay patients who pay in full at time of service. Payment is expected at each visit. All other ancillary, treatment and future care will be reviewed with you in order to make arrangements for payment.

EVENING AND WEEKEND APPOINTMENTS

We offer limited evening (after 5 pm) and weekend appointments as a convenience for our patients. To offset the additional cost to our practice for operating outside of regular business hours, we charge a $20 fee for appointments scheduled during these hours. This charge is in addition to any other charges for your appointment. Most commercial insurers cover this additional charge. If your insurer does not cover this charge, you will be responsible for payment in full.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT

We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you a fee for any no-show if permitted by law and your insurance contract. A higher fee may be assessed for a missed evening or weekend appointment. Payment of the missed appointment will be required prior to scheduling another appointment. Wexford Allergy, Asthma & Immunology, LLC, reserves the right to terminate any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late for an appointment, Wexford Allergy, Asthma & Immunology, LLC, may reschedule your appointment and refuse to see you at the originally scheduled time.

REFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, we will be unable to treat you until a valid authorization/referral is obtained, and you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment will be expected at the time of service. Please remember that it is your responsibility to make sure we are on your plan's provider listing. We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies or requirements.

FORMS AND MEDICAL RECORDS FEES

Due to the increasing costs of providing our patients with the highest standards of care, we must impose a charge for certain records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. The following charges apply:

FMLA, Disability, Corps, School forms not completed during an appointment, and Supplemental insurance forms $15.00

Dictated letters, extensive forms with review of medical records $25.00 per page

Copies of records for personal use will be charged the allowed fee by the Commonwealth of Pennsylvania.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid and commercial insurance benefits be made on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or any other insurer and its agents, any information needed to determine these benefits or the benefits payable for related service.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Wexford Allergy, Asthma & Immunology, LLC, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Wexford Allergy, Asthma & Immunology, LLC: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by Wexford Allergy, Asthma & Immunology, LLC. This order will remain in effect until revoked by me in writing.

I have received the practice's Medical Authorization for Release / Disclosure of Protected Health Information / HIPAA Privacy Notice.

_____
Patient Name (PRINT)

_____
Name of Person Financially Responsible
(PRINT)

_____ _____
SIGNATURE Date
of Person Financially
Responsible for Patient's Treatment

Revision Date: November 6, 2019