Allergy, Asthma Associates, P.C.
Nabeeh N. LaHood, M.D. Pierre Sakali, M.D
Skin Testing Patient Instructions

- *2320 N. Wyatt Drive, Suite 71, Tucson, AZ 85712 (520)318-1860*
- *7510 N. Oracle Road, Suite 202, Tucson, AZ 85704 (520)531-9254*
- *1760 E. Florence Blvd., Suite 200, Casa Grande, AZ 85122 (520)836-3283*

- **Plan to be in our office 1 ½ to 2 ½ hours (depending on the level of treatment required)**
- **Please do not wear perfume or cologne to our office due to the nature of our practice.**

Medication list for Patients who will have Allergy Skin Testing

- **You may continue to take the following medications:**

*** Antibiotics *Asthma medications (including inhalers) * Heart medications**
*** Prednisone (Unless scheduled for Patch Testing)**

***All Nasal Sprays may be continued except:**
Discontinue for one week *Astelin *Astepro * Patanase * Dymista

- **You must discontinue the following medications as listed below so your skin testing results will be accurate:**

*** All antihistamine medications as follows:**

Off for three weeks:	***Hismanal (Astemizole)**
Off for one week:	***Alavert (Loratadine) *Allegra (Fexofenadine) *Clarinex (Desloratadine) *Claritin (Loratadine)**
Off for five days:	*** Tavist *Zyrtec (Cetirizine)**
Off for three days:	***Antivert *Atarax (Hydroxyzine) *Bromfenex *Semprex D *Xyzal * Zantac *Any eye drops**
Off for two days:	***Atrohist (Chlorpheniramine +) *Bromfed *Phenergan (Dextromethorphan) *R-tannate *Cardec DM (Brompheniramine) *Chlor-trimeton (Chlorpheniramine) *Dimetane (Brompheniramine) *Extendryl (Chlorpheniramine +) *Nolahist (Chlorpheniramine +) *PBZ (Tripelennamine) *Periactin (Cyproheptadine) *Delphim *Deconamine *Tylenol Severe Sinus * Mucinex * Sudafed**
Off for one day:	***Benadryl *Any over-the-counter medication not mentioned *Unisom *Sleep aid (Doxylamine Succinate Tablets)**

*** All cough medicines two days prior to skin testing appointment.**

Decongestants may be continued as long as they are not combined with Antihistamines.

If you have difficulty discontinuing your allergy medications, you may take Benadryl up to one day before your skin testing. (May be purchased over the counter.) If you continue to have difficulty please notify us immediately.

This is not a complete list of medications. Please ask or call us if you have questions about other medications that you may be taking that are not mentioned above.

WELCOME TO ALLERGY ASTHMA ASSOCIATES P.C.

Please print clearly and complete ALL Registration Information

Patient Information

Patient first name_____ Patient last name _____Middle_____
S.S.N. ____ ____ ____ D.O.B. ____ ____ ____ Gender _____
Permanent home address:
Street_____ Apt # _____ City_____ State _____ Zip_____
Home Phone _____ _____ _____ Work Phone _____ _____ _____
Cell Phone _____ _____ _____ May we call you on your cell? Yes No Preferred Phone _____ _____ _____
Mailing address:
Street _____ City _____ State _____ Zip _____
Email _____
Emergency Contact _____ Phone _____

For government meaningful use requirement, we ask the following

Race _____ Refuse to report _____
Ethnicity _____Refuse to report _____ Preferred Language_____

Patient Pharmacy name _____ Phone # _____ _____ _____
Primary Care physician _____ Phone # _____ _____ _____
Referring Physician _____ Phone # _____ _____ _____

Patient Billing:
Send statement to _____ Relationship to the patient _____

Address _____ City _____ State_____ Zip_____

Patient primary Insurance

Ins. Name _____ Member ID# _____ Group #_____
Start date ____ ____ ____ Co pay $ _____
Insured name_____ Relationship to patient_____
Insured D.O.B. ____ ____ ____ Insured Address _____City _____ State_____Zip_____
Insured Employer _____

Patient Secondary Insurance

Ins. Name _____ Member ID# _____ Group #_____
Start date _____ _____ ____ Co pay $ _____
Insured name_____ Relationship to patient_____
Insured D.O.B. ____ ____ ____ Insured Address _____City _____ State____ Zip_____
Insured Employer _____

Patient Signature: _____ Date: _____

Guardian Signature/ Patient is Minor: _____ Date: _____

Guardian Full Name: _____Relation: _____

Minor's Father Name: _____ Minor's Mother Name: _____

AUTHORIZATION FOR TREATMENT OF MINOR
AGES 0-18 YEARS
Please read thoroughly before signing

Patient's Full Legal Name:

First_____Last_____Middle_____

For patients ages 0-15 years

I authorize the following adult individuals to accompany the above-mentioned minor to the offices of ALLERGY, ASTHMA ASSOCIATES, P.C. for the purposes of obtaining medical care. This medical care may include any treatment or diagnostic procedure the Dr.'s may see necessary that includes allergy shots. I understand, if the patient is on allergy shots, that I am required to sign for antigens to be made.

Please also list parents:

Name_____ Relationship to patient_____Phone_____

Name_____ Relationship to patient_____Phone_____

Name_____ Relationship to patient_____Phone_____

Name_____ Relationship to patient_____Phone_____

Admitting Parent/Legal Guardian Signature_____Date_____

****Please be aware, a non-custodial parent, whose insurance covers this patient, will have full access to the patient's Medical Records even if this parent is not listed above.**

For patients ages 16-18 years

I authorize the above-mentioned minor child to receive medical care from ALLERGY, ASTHMA ASSOCIATES, P.C. without being accompanied by an adult. I understand, if the patient is on allergy shots that I am required to sign for antigens to be made.

Admitting Parent/Legal Guardian Signature_____ Date_____

Allergy, Asthma, Associates, P.C.

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(520) 836-3283

Fax # (520) 318-1859 (all locations)

Please list all medications you are currently taking.

Medication	Strength	Dose

Patient Name:_____ Date of Birth: _____

ALLERGY, ASTHMA, ASSOCIATES, P.C.
FINANCIAL POLICY

Patient Name:
****We would like you to please thoroughly read each section of our financial policy**

Thank you for choosing ALLERGY, ASTHMA ASSOCIATES, P.C. for your medical care.
Our Mission is to provide our patients with exceptional medical care. We are also committed to having a mutually respectful relationship with each and every patient.

BASIC POLICY

Payment in full is due at the time of services provided, **this includes co-pays, co-insurance and deductibles, please be prepared to make payment at the time of your visit.**
Any remaining balance assigned to you after the claims have been processed by your insurance company will be forwarded to you. Balance is due upon receipt of your statement**.**
Please be advised that, there will be $25.00 handling fee for any returned check, patient balance over 60 days old may be subject to additional collection fee and unpaid balance over 120 days old may be turned over to a collection agency.

In order for us to service our account or to collect any amounts you may owe, that we may contact you by telephone at any telephone number associated with your account, including wireless telephone number. Methods of contact may include using pre-recorded/artificial voice message and /or of an automatic dialing device as applicable.

MEDICAL INSURANCE COVERAGE

While we are contracted to provide services for numerous insurance companies, we will file all claims to your insurance, we are **not** in a position to be familiar with every different plan and its coverage. **PLEASE be familiar with the specific health care benefits of your medical insurance before you are seen in our office**. If you have any questions regarding your health coverage, please call the customer service representative for your insurance company, they will be happy to explain your plan coverage. It is very important that you keep our office advised of all changes in your personal information including Primary Care Physician, insurance coverage, address and phone numbers.

NONCOVERED SERVICES

You are responsible to pay charges at the time of service for any treatments or procedures provided to you by our office that is **not covered** by your insurance.

PATIENT RESPONSIBILITY

If your insurance requires a referral or prior authorization it is your responsibility to assure that one is available to our office prior to or at the time of your service. Please request that your primary care physician fax the referral or the authorization to our office at 520-318-1859.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign all medical benefits for any services furnished to me to Allergy Asthma Associates, P.C. this assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I have read, understand and agree to the above Financial Policy of ALLERGY, ASTHMA, ASSOCIATES, P.C. for payment and professional fees.

Patient Signature: _____ Date: _____
(Patient or if minor, parent or legal guardian signature)

If minor, relationship: _____

Allergy, Asthma, Associates, P.C.

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, direct Allergy Asthma Associates, P.C. to disclose my protected health information as described below to:

Name: _____ Relationship: _____

Phone: _____ Address: _____

INFORMATION TO BE DISCLOSED:

The following is a specific description of the health information I authorize to be disclosed:

(Check all that apply)

□ Complete Record □ Appointment Information □ Laboratory Results □ Progress Notes

□ Diagnosis □ Claims/Billing History □ Progress □ Treatment

□ Other (Please Specify): _____

This authorization to disclose protected health information to the individual named above pertains to health information obtained during:

□ During all past, present, and future periods. **OR** □ From _____ to _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

□ At the request of the individual named □ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of this Authorization – I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign this Authorization** – I understand that I am under no obligation to sign this form and that Allergy Asthma Associates, P.C. may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization if such conditioning is prohibited by the privacy rule. **Right to Revoke this Authorization** – I understand that I have the right to revoke this authorization at any time by providing a written statement of revocation to Allergy Asthma Associates, P.C., 2320 N. Wyatt Drive Ste #71 Tucson, AZ, 85712. I am aware that my revocation will not be effective until received by Allergy Asthma Associates, P.C. and will not be effective regarding the uses and/or disclosures of my health information that Allergy Asthma Associates, P.C. has made prior to receipt of my revocation statement. **Right to Inspect or Copy the Health Information to Be Disclosed** – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Allergy Asthma Associates, P.C.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is valid until (indicate date or event)_____

By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL GUARDIAN: _____ DATE: _____