Allergy, Asthma, Associates, P.C.

Nabeeh N. LaHood, M.D. ♦ Pierre Sakali, M.D. ♦ Nicole A. LaHood, M.D.

Skin Testing Patient Instructions

° ***1500 N. Wilmot Road, Suite A110, 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 your prescribed medications, including (but not limited to):

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

*All Nasal Sprays may be continued except for the following (discontinue for one week):
*Astelin (Azelastine) *Astepro * Patanase (Olopatadine) * 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 3 WEEKS:	***Hismanal (Astemizole)**
OFF FOR 1 WEEK:	***Alavert (Loratadine) *Allegra (Fexofenadine) *Clarinex (Desloratadine) *Claritin (Loratadine)**
OFF FOR 5 DAYS:	*** Tavist *Zyrtec (Cetirizine)**
OFF FOR 3 DAYS:	***Antivert *Atarax (Hydroxyzine) *Bromfenex *Semprex D *Xyzal (Levocetirizine)** *** Zantac *Any antihistamine eye drops *Doxepin *Pepcid *Ranitidine *Famotidine**
OFF FOR 2 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 *ZzzQuil *Dramamine (Dimenhydrinate) *Bonine (Meclizine) *Transderm Scop (Scopolamine)**
OFF FOR 1 DAY:	***Benadryl *Any over-the-counter allergy or cold medication not mentioned *Unisom** ***Sleep aid (Doxylamine Succinate Tablets) *NyQuil**

*** 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 our office if you have questions about any other medications 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: _____

Allergy, Asthma, Associates, P.C.

Nabeeh N. LaHood, M.D. ♦ Pierre Sakali, M.D. ♦ Nicole A. LaHood, M.D.
Donna Eubanks, F.N.P.

1500 N. Wilmot Rd, Ste A110
Tucson, Arizona 85712
(520) 318-1860

7510 N. Oracle Rd, Ste 202
Tucson, Arizona 85704
(520) 531-9254

1760 E. Florence Blvd, Ste 200
Casa Grande, Arizona 85122
(520) 836-3283

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

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 be any treatment or diagnostic procedure the Dr.'s may find necessary, including 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:

1.) _____ Relation to Patient: _____ Phone: _____

2.) _____ Relation to Patient: _____ Phone: _____

3.) _____ Relation to Patient: _____ Phone: _____

4.) _____ Relation to Patient: _____ Phone: _____

5.) _____ Relation 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. **I understand I must be present for any scheduled office appointments**.

Admitting Parent/Legal Guardian Signature: _____ Date: _____

Allergy, Asthma, Associates, P.C.

Nabeeh N. LaHood, M.D. ♦ Pierre Sakali, M.D. ♦ Nicole A. LaHood, M.D.
Donna Eubanks, F.N.P.

1500 N. Wilmot Rd, Ste A110
Tucson, Arizona 85712
(520) 318-1860

7510 N. Oracle Rd, Ste 202
Tucson, Arizona 85704
(520) 531-9254

1760 E. Florence Blvd, Ste 200
Casa Grande, Arizona 85122
(520) 836-3283

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

Medication List

(please list all medications you are currently taking)

Medication	Strength	Dose

Patient Name:_____ Date of Birth: _____

Allergy, Asthma, Associates, P.C.

Nabeeh N. LaHood, M.D. ♦ Pierre Sakali, M.D. ♦ Nicole A. LaHood, M.D.
Donna Eubanks, F.N.P.

1500 N. Wilmot Rd, Ste A110
Tucson, Arizona 85712
(520) 318-1860

7510 N. Oracle Rd, Ste 202
Tucson, Arizona 85704
(520) 531-9254

1760 E. Florence Blvd, Ste 200
Casa Grande, Arizona 85122
(520) 836-3283

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

FINANCIAL POLICY

Patient Name: _____

(We would like you to please read each section of our financial policy thoroughly)

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-pay, co-insurance and deductible amounts, please be prepared to make this payment at the time of your visit.**

Any remaining balance assigned to you after your medical claims have been processed by your insurance company will be forwarded to you. Balance is due upon receipt of your statement**.**
Please be advised there will be $25.00 handling fee for any returned check. Any patient balance over 60 days old may be subject to additional collection fees and any 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, we may contact you by telephone at any telephone number associated with your account. Methods of contact may include using pre-recorded/artificial voice message and/or automatic dialing devices as applicable.

MEDICAL INSURANCE COVERAGE

We will file all claims to your insurance company. While we are contracted to provide services for numerous insurance companies, we are **not** in a position to be familiar with every different plan and its coverage. **PLEASE familiarize yourself with the specific health care benefits of your medical insurance plan 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: _____
(If minor, Parent or Guardian)

If minor, relationship to patient: _____

Allergy, Asthma, Associates, P.C.

Nabeeh N. LaHood, M.D. ♦ Pierre Sakali, M.D. ♦ Nicole A. LaHood, M.D.
Donna Eubanks, F.N.P.

1500 N. Wilmot Rd, Ste A110
Tucson, Arizona 85712
(520) 318-1860

7510 N. Oracle Rd, Ste 202
Tucson, Arizona 85704
(520) 531-9254

1760 E. Florence Blvd, Ste 200
Casa Grande, Arizona 85122
(520) 836-3283

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

PATIENT AUTHORIZATION FORM

Authorization for Disclosure of Protected Health Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the results of tests, procedures, and financial information. Under the requirements of H.I.P.A.A we are not allowed to give this information to anyone without the patients consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Allergy, Asthma, Associates, P.C. to release my records and any information requested to the following individuals:

1.) _____ Relation to Patient: _____

2.) _____ Relation to Patient: _____

3.) _____ Relation to Patient: _____

4.) _____ Relation to Patient: _____

5.) _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

___ I authorize Allergy, Asthma, Associates, P.C. to leave a detailed message on my home or cell number regarding appointments.

___ I authorize Allergy, Asthma, Associates, P.C. to leave a detailed message on my home or cell number regarding medical treatment, care, test results, or financial information.

___ I authorize Allergy, Asthma, Associates, P.C. to leave a message with anyone who answers my home or cell number.

___ Messages may only be left with _____

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

Patient Signature: _____ Date: _____
(If minor, Parent or Guardian)