ALLERGY & ASTHMA ASSOCIATES OF MAINE, P.A.

Main Office	Manchester Office	Lewiston Office	Kennebunk Office	Falmouth Office
195 Fore River Pwky	1053 Western Ave	33R Mollison Way	2 Independence Drive	170 US Route One
Suite 410	Manchester, ME 04351	Lewiston ME 04240	Kennebunk ME 04043	Suite 100
Portland, ME 04102				Falmouth, ME 04105

An appointment has been made for you at Allergy and Asthma Associates of Maine. Enclosed is the **required** NEW PATIENT PAPERWORK. Even though all the questions may not seem pertinent, it is important that these forms are filled out as accurately as possible. This information will assist in determining your diagnosis and what mode of therapy to prescribe. **PLEASE BRING THESE FORMS WITH YOU ON THE DAY OF YOUR APPOINTMENT OR ARRIVE 15 MINUTES EARLY.** Please have your physician send us any records regarding your reason for coming and any chest or sinus x-rays or CT scan results from the past few years. They can **fax your records to 207-761-2127.** IF YOU ARE TO BE EVALUATED FOR EXERCISE INDUCED ASTHMA, PLEASE WEAR APPROPRIATE RUNNING SHOES.

NEW PATIENT APPOINTMENTS MAY LAST FROM 2-3 HOURS DEPENDING ON THE AMOUNT OF TESTING DONE. WE RESERVE THE RIGHT TO REFUSE TO SEE ANY PATIENT THAT IS MORE THAN 10 MINTUES LATE FOR THEIR APPOINTMENT. IF YOUR PROBLEM IS FELT TO BE ALLERGY RELATED, TESTING MAY BE DONE DURING YOUR FIRST VISIT. ALLERGY TESTING CAN BE EXPENSIVE. OUR PROVIDERS WILL ONLY RECOMMEND WHAT IS REASONABLE FOR YOUR CARE. IF YOU HAVE INSURANCE, YOUR INSURANCE MAY COVER YOUR VISIT AND TESTING, BUT DEPENDING ON YOUR DEDUCTIBLE AND CO-INSURANCE, YOU MAY BE RESPONSIBLE FOR PART OR ALL OF THE COST. IF LABORATORY TESTING, X-RAYS OR CT SCANS ARE ORDERED, THESE ALSO MAY NOT BE FULLY COVERED IF APPLIED AGAINST YOUR DEDUCTIBLE OR CO INSURANCE. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE PRIOR TO YOUR APPOINTMENT.

IN ORDER FOR ALLERGY TESTING TO BE DONE AT YOUR FIRST VISIT: To get accurate results from the testing, certain medications need to be stopped. **MEDICATIONS TO BE STOPPED INCLUDE ALL ANTIHISTAMINES**. Below is only a partial list. If a medication is not listed and you are concerned that it may interfere with testing, please give us a call approximately one week before your appointment or talk to your physician.

STOP 7 DAYS BEFORE APPOINTMENT (long acting antihistamines)

ALAVERT	CETIRIZINE	CLARINEX	HYDROXYZINE	XYAL-LEVOCETIRIZINE
ALLEGRA	CLARITIN	CLARINEX-D	LORATADINE	ZYRTEC
ALLEGRA-D	CLARITIN D	DIMETAPP-ND	MECLIZINE	ZYRTEC-D
ATARAX	CLARITIN REDI-TABS	DOXEPIN	TAVIST-ND	ZYRTEC SYRUP
	CLARITIN SUSP	FEXOFENADINE	VISTARIL	

STOP 3 DAYS BEFORE APPOINTMENT (short acting antihistamines)

ADVIL PM	AZELASTINE-VISTARIL	DIPHENHYDRAMINE	PATANASE NASAL SPRAY	TYLENOL PM
ALLEREST	BENADRYL	DRIXORAL	PERIACTIN	TRIAMINIC
ALKA-SELTZER PLUS	CHLORPHENIRAMINE	NYQUIL	SUDAFED PLUS	
ASTELIN NASAL SPRAY	CHLOR-TRIMETON	OPTIMINE	TAVIST	
ASTEPRO NASAL SPRAY	CONTAC		TAVIST -D	

***Please be aware that various sleep or cold medications contain antihistamines, and these need to be stopped as well.**

Tricyclic antidepressants (e.g. amitriptyline), some psychiatric medications and certain ulcer medications (Zantac, Pepcid, Axid, and Tagament) may affect skin testing. Many psychiatric medications need to be stopped 3-7 days before testing and most ulcer and reflux medications (except Prilosec, Prevacid, Omeprazole, Nexium, etc.) should be stopped 1 day before testing. Please contact your prescribing physician before stopping these medications. *If you have any questions, please call us at 207-774-9839.*
If you feel you cannot stop one of the above medications without becoming sick, you may remain on your medication.
Medications that you do NOT need to stop prior to your appointment:

- **Sudafed (pseudoephedrine)**
- **Oral and inhaled corticosteroids (e.g. Prednisone, Medrol, Vanceril, Asmanex, Alvesco, Astepro, Pulmicort, Advair, Flovent, QVAR, Nasacort, Rhinocort, Vancenase, Flonase, Nasonex, Veramyst, Astelin, Omnaris, Dulera Ect.)**
- **Antiobiotics**
- **Pure Theophylline preparations (e.g. Slo-Bid, Uniphyl, Theo-Dur, Quibron)**
- **Brochodialator inhalers (e.g. Proventil, Ventolin, Serevent, Maxair, Atrovent, Foradil, etc.)**
- **Cromolyn Sodium (e.g. Intal) and Nedocromil Sodium (e.g. Tilade)**
- **Singulair**

REGISTRATION FORM

1. **PATIENT INFORMATION**

LAST NAME:_____FIRST NAME:_____MI:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SEX (CIRCLE): M F PATIENT SSN:_____--_____--_____DATE OF BIRTH (MM/DD/YYYY):_____/_____/_____

PREFERRED PHONE (_____)_____--_____WORK PHONE (_____)_____--_____CELL PHONE (_____)_____--_____

IN CASE OF EMERGENCY CALL: NAME:_____PHONE (_____)_____--_____RELATIONSHIP:_____

RACE: (CIRCLE ONE BELOW)
AMERICAN INDIAN/ALASKA NATIVE
ASIAN
BLACK/AFRICAN AMERICAN
DECLINED
NATIVE HAWAIIAN/PACIFIC ISLANDER
OTHER RACE
WHITE/CAUCASIAN

ETHNICITY: (CIRCLE ONE BELOW)
DECLINED
HISPANIC OR LATINO
NOT HISPANIC OR LATINO

EMAIL ADDRESS:_____

PREFERRED PHARMACY:
_____
CITY:_____
STATE:_____

PREFERRED COMMUNICATION: (CIRCLE BELOW)
TELEPHONE TEXT E-MAIL MAIL DECLINED
PATIENT PORTAL OTHER:_____

2. **RESPONSIBLE PARTY** (FILL OUT IF PATIENT IS UNDER 18)

MOTHER/OTHER

LAST NAME:_____FIRST NAME_____MI:____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
HOME PHONE (_____)_____--_____
WORK PHONE (_____)_____--_____
CELL PHONE (_____)_____--_____
RELATIONSHIP TO PATIENT:_____

FATHER/OTHER

LAST NAME:_____FIRST NAME_____MI:____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
HOME PHONE (_____)_____--_____
WORK PHONE (_____)_____--_____
CELL PHONE (_____)_____--_____
RELATIONSHIP TO PATIENT:_____

3. **PATIENT EMPLOYMENT INFORMATION**

EMPLOYER:_____
EMPLOYER ADDRESS:_____
CITY:_____STATE_____ZIP:_____

4. **REFERRING PHYSICIAN** (*THIS IS THE DOCTOR WHO REFERRED YOU TO OUR PRACTICE*)

PHYSICIAN NAME:_____
PRACTICE NAME (IF ANY):_____
CITY:_____STATE_____ZIP:_____
PHONE (_____)_____--_____
FAX (_____)_____--_____

DO YOU NEED A REFERRAL (CIRCLE): YES NO

INSURANCE INFORMATION

FAILURE TO COMPLETE THIS SECTION MAY RESULT IN AN INABILITY TO PROPERLY BILL YOUR INSURANCE CARRIER. PLEASE PROVIDE US WITH YOUR INSURANCE CARD AT TIME OF APPOINTMENT.

IF YOU HAVE SECONDARY INSURANCE, YOU WILL NEED TO COMPLETE THE SECONDARY INURANCE FORM ON THE BACK OF THIS FORM.

1. **PRIMARY INSURANCE POLICY INFORMATION:**

CARRIER:_____
INSURANCE ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
POLICY#_____GROUP#_____

2. **INSURANCE POLICY HOLDER** (*PERSON WHOSE EMPLOYER CARRIES THE INSURANCE POLICY*)

LAST NAME:_____FIRST NAME:_____MI:___
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
DOB(MM/DD/YYY):_____/_____/_____
SSN:_____--_____--_____
HOME PHONE (_____)_____--_____
RELATIONSHIP TO PATIENT:_____

3. **POLICY HOLDER'S EMPLOYMENT**

EMPLOYER:_____
EMPLOYER ADDRESS:_____
CITY:_____STATE:_____ZIP:_____

PRIMARY CARE PHYSICIAN OF PATIENT (*IF SAME AS REFERRING PHYSICIAN, CHECK THIS* □)

PHYSICIAN NAME:_____
PRACTICE NAME (IF ANY):_____
CITY:_____STATE:_____ZIP:_____
PHONE(_____)_____--_____

BY SIGNING BELOW, I ATTEST THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE

***SIGNATURE* OF INSURED/GUARDIAN:_____DATE___/___/____**

REGISTRATION

SECONDARY INSURANCE INFORMATION

FAILURE TO COMPLETE THIS SECTION MAY RESULT IN AN INABILITY TO PROPERLY BILL YOUR INSURANCE CARRIER. ***PLEASE PROVIDE US WITH YOUR INSURANCE CARD AT TIME OF APPOINTMENT.***

1. SECONDARY INSURANCE POLICY INFORMATION:

CARRIER:_____

INSURANCE:_____

CITY:_____STATE:_____ZIP:_____

POLICY #:_____GROUP#:_____

2. INSURANCE POLICY HOLDER (*THIS IS THE PERSON WHOSE EMPLOYER CARRIES THE INSURANCE POLICY***):**

LAST NAME:_____FIRST NAME:_____MI:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

POLICY HOLDER DOB (MM/DD/YYY):_____/_____/_____

SSN:_____--_____--_____ SEX (CIRCLE): M F

HOME PHONE (_____)_____--_____

RELATIONSHIP TO PATIENT:_____

3. POLICY HOLDER'S EMPLOYMENT

EMPLOYER:_____

EMPLOYER ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

Allergy & Asthma Associates of Maine, P.A.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I consent to Allergy and Asthma Associates of Maine, PA's use and disclosure of my protected health information (PHI) in support of my diagnosis and treatment, payment for the medical services I receive and the legitimate health care operations of the medical practice.

I consent to Allergy and Asthma Associates of Maine, PA's disclosure to other healthcare practitioners and facilities that are involved in providing medical services to me.

I understand that Allergy and Asthma Associates of Maine, PA will disclose only the minimum amount of my health care information which is necessary, in judgment of Allergy and Asthma Associates of Maine, PA for the legitimate needs of the recipient or for my general well-being.

My PHI, which is the subject of this consent, includes demographic information, information about my physical or mental health condition, information about the medical services provided to me, including payment information if that information is required to identify me. Depending upon the medical services, I request or require, this information may include information about treatment for mental health or psychiatric conditions. I do request that this not include treatment information for HIV/AIDS, sexually transmitted diseases or substance abuse unless a separate authorization form is signed by me ordering this information to be released.

I understand that I have the right to restrict Allergy and Asthma Associates of Maine, PA's use and disclosure of my PHI and that Allergy and Asthma Associates of Maine, PA is not obligated to agree to the requested restriction, but that an agreement to a restriction binds Allergy and Asthma of Maine, PA. I may revoke this consent at any time by providing Allergy and Asthma Associates of Maine, PA with a written, signed and dated request except to the extent that Allergy and Asthma Associated of Maine, PA has acted in accordance to my consent.

However I understand that any restriction on the use of disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

I acknowledge that this consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined above for 30 months from the date of this consent unless I revoke it earlier as described above.

I understand that Allergy and Asthma Associates of Maine, PA regards the safeguarding of PHI as an important duty. I understand, furthermore, that the elements of this consent are required by state and federal law for my protection and to ensure my informed consent to the use and disclosure of PHI necessary to support my relationship with Allergy and Asthma Associates, PA.

I have been offered a complete copy of the Allergy and Asthma Associates of Maine, PA Notice of Privacy Practices that provides a detailed description of the uses and disclosure addressed above and I have had the opportunity to review the notice of Privacy Practices prior to signing this consent should I choose to do so. I acknowledge that Allergy and Asthma Associates, PA reserves the right to amend the Notice of Privacy Practices periodically. I understand that I may obtain a current copy of the Notice by contacting the office staff at any time.

I understand that if I have any questions about this consent or about Allergy and Asthma Associates of Maine, PA's privacy practices, or if I wish to have a copy of this consent, I may ask the office staff or my physician.

_____ _____

PATIENT NAME **DATE**

_____

SIGNATURE OF PATIENT or PARENT/LEGAL GUARDIAN

I ALSO AUTHORIZE_____WHOSE RELATION TO ME IS_____
TO ACCESS MY PROTECTED HEALTH INFORMATION UNTIL I REVOKE THIS CONSENT IN WRITING.

Allergy & Asthma Associates of Maine
Consent to Treat

*****YOU MUST SIGN THE CONSENT BOX BELOW IN ORDER TO RECEIVE TREATMENT*****

TREATMENT

I CONSENT TO DIAGNOSTIC PROCEDURES AND MEDICAL CARE AS NECESSARY IN THE JUDGMENT OF MY DOCTOR. I UNDERSTAND THAT MY DOCTOR WILL EXPLAIN TO ME THE PURPOSE OF, THE BENEFITS, AND THE USUAL RISKS AND HAZARDS INVOLVED IN THE DIAGNOSIS AND TREATMENT OF ANY ILLNESS OR INJURY, AS WELL AS ALTERNATIVE COURSES OF TREATMENT. I FURTHER UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE ANY SUGGESTED EXAMINATIONS, TESTS, OR TREATMENT. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF TREATMENT OR EXAMINATION.

BY SIGNING BELOW I ALSO ALLOW MY PROVIDER ACCESS TO MY PHARMACY RECORDS IF NECESSARY FOR OPTIMIZING MY MEDICAL TREATMENT.

SIGNED:_____DATE:_____
PATIENT

SIGNED:_____DATE:_____
PATIENT PARENT/LEGAL GUARDIAN

FINANCIAL POLICY
ALLERGY & ASTHMA ASSOCIATES OF MAINE, P.A.

Thank you for choosing Allergy & Asthma Associates of Maine P.A. as one of your healthcare providers. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. The following is a summary of our Financial Policies and an explanation of your responsibilities. Please feel free to ask if you have **ANY** questions about our fees or your financial responsibility. By signing below you accept responsibility for your charges and authorize us to bill your insurance, on your behalf, for services provided to you.

Your initial consult will result in average charges between $250.00 and $1000.00. The initial charges include a consultation fee consisting of a detailed history and physical examination. There also will be fees for any testing (allergy skin testing and pulmonary function testing,) if performed during the course of your visit. **Please Note*** ** We will submit your claim for all services provided to your insurance company. Depending on your deductible and coinsurance, you may be responsible for all or part of the cost of your care, as determined by your contract with your insurance carrier. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. By presenting for care, you agree that you are responsible for all charges, regardless of your insurance status or coverage.

WE MAY ASK TO SEE YOUR INSURANCE CARD AT EVERY VISIT IN ORDER TO KEEP OUR INFORMATION CURRENT.

REFERRALS: If your insurance plan requires a referral from your Primary Care Physician, it is your responsibility to obtain it prior to your appointment. If you do not have a valid referral on file, you may be financially responsible for the visit.

CO-PAYMENTS: Some health insurance carriers require the patient to pay a co-pay at the time of service. Please be prepared to **pay your co-pay at the time of your appointment**. Co-payments that are not paid at the time of service will be billed to you with an **additional $10 fee** for administrative costs, postage, billing time, supplies, etc.

SELF-PAY: If you do not have insurance coverage, we are happy to work with you to set up a payment plan. If you are a new patient, a $100.00 deposit will be required at your first visit, prior to seeing the provider. Allergy testing will not be performed on your first visit unless you have talked with our billing specialist and arranged for payment.

RETURNED CHECK FEES: Any check returned from the bank for non-payment (insufficient funds), shall result in the patient's account being charged a $25.00 fee per returned check.

DIVORCE: In divorce situations, the parent who brought the child in is responsible for payment of the bill. We will file with any insurance company we have a contractual agreement with.

MONTHLY STATEMENTS: Any outstanding balance is due immediately upon receipt of our statement. We accept payment by Visa, Mastercard, Discover or check. Failure to pay your balance or set up payment arrangements within 90 days may result in the account being turned over to our collection agency and the patient being discharged from the practice.

Missed Appointments: We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we require 24 hrs notice for all cancelled appointments. New Patients that miss an appointment will be charged a $75.00 reinstatement fee to reschedule. If you are an established patient and fail to give 24 hrs notice to cancel your appointment or do not show up for your appointment, a $50 missed appointment fee will need to be paid to reschedule the appointment. More than two missed appointments may result in the patient being discharged from the practice. The Practice will notify you in writing, via certified mail, if you are discharged from care. Please realize that a missed appointment leaves an opening that could have been filled by a patient waiting to be seen in our office.

Patient Name: _____

PATIENT/PARENT SIGNATURE _____ **DATE:** _____