Allergy, Asthma & Sinus Center, PLLC

NEW PATIENT INFORMATION

The following information is provided to you in order to make your visit(s) to our office as convenient for you as possible.

PLEASE CALL YOUR INSURANCE COMPANY TO CHECK YOUR BENEFITS

- Please return the enclosed Registration and HIPAA forms when you come for your initial visit.
- On your testing visit, please allow a minimum of 2 hours for the appointment.
- If for any reason, you cannot keep your appointment, please notify us as soon as possible so we may free up the space for another patient in need of care.
- Copies of any lab work, x-ray reports, previous allergy studies, or other pertinent medical studies may be important and should either be sent beforehand or brought along.

Please stop taking the following medications for the amount of time specified:

- CANNOT HAVE THE FOLLOWING:
  - **Claritin/Loratidine** – *5 days* **Xyzal /Levocetirizine**– *5 days*
    Allegra/fexofenadine – *5 days* **Zyrtec/Cetirizine** – *5 days*
    Clarinex/Desloratidine– *5 days* **Amitriptylline** – *5 days*
  - Any over the counter cold and cough, sinus medication such as **Tylenol Cold and Sinus, Dimetapp**
  - Certain antidepressants (**Elavil**, **Sinequan (Doxepin)**, **Imipramine)** – *5 days*
  - Other Antihistamines:**Benadryl (dyphenhydramine)**, **Atarax (hydroxyzine)**, **Phenegran (Promethazine), D-allergy, Bromfed, Chlor-Trimeton**, & **Actifed**, etc – *3 days*
  - Over-the-counter sleeping medication – *3 days*
  - Other drugs to avoid for *48 hours* prior to appointment: **Zantac (Ranitidine), Pepcid (famotidine)** and **Tagament (Cimetidine HCl)**
  - **All other medications including other antidepressants not listed above should be continued as prescribed. If you have any questions regarding a specific medication, please consult your pharmacy or prescribing provider.**
- PLEASE CONTINUE: **Dulera, Advair, Q-Var, Singulair, Symbicort, & all nasal sprays**

Allergy testing cannot be administered if you have Antihistamines in your system.

REGISTRATION FORM

ALLERGY, ASTHMA, AND SINUS CENTER, PLLC
1136 MONARCH ST LEXINGTON, KY 40513
PH: (859)223-0000 FAX: (859)223-0602

EMAIL ADDRESS (FOR ACCESS TO PATIENT RECORDS) _____

PATIENT LAST NAME: _____ MI: ____ FIRST: _____

GENDER: M / F SSN: _____-____-_____ DOB: ____/____/_____

ADDRESS: _____ CITY: _____ ST/ZIP: _____

HOME PHONE: _____ WORK/CELL: _____

RACE/ETHNICITY: _____ PREFERRED LANGUAGE: _____

EMERGENCY CONTACT_____PHONE_____

MAY WE CONTACT YOU BY PHONE AND LEAVE A MESSAGE ON YOUR VOICE MAIL? YES ____ NO ____

PRIMARY CARE PHYSICIAN: FIRST NAME: _____ LAST NAME: _____

REFERRING PHYSICIAN (IF DIFFERENT): FIRST NAME: _____LAST NAME: _____

IF PATIENT IS UNDER THE AGE OF 18:

MOTHER _____ DOB: _____/_____/_____ SSN: _____

ADDRESS (IF DIFFERENT): _____ CITY: _____ ST/ZIP: _____

FATHER _____DOB: _____/_____/_____ SSN: _____

ADDRESS (IF DIFFERENT): _____CITY _____ST/ZIP_____

WE DO NOT PARTICIPATE W/HUMANA HMO OR HUMANA MEDICARE

PRIMARY INSURANCE CO: _____

POLICY HOLDER'S NAME: _____ RELATION TO PATIENT: _____

POLICY HOLDER'S DOB: ____/____/_____ POLICY HOLDER'S SSN: _____-____-_____

MEMBER ID: _____ GROUP: _____ CO PAY: $_____ EFFECTIVE_____

SECONDARY INSURANCE CO: _____

POLICY HOLDER'S NAME: _____ RELATION TO PATIENT: _____

POLICY HOLDER'S DOB: ____/____/_____ POLICY HOLDER'S SSN: _____-____-_____

MEMBER ID: _____ GROUP: _____ CO PAY: $_____ EFFECTIVE_____

Allergy, Asthma & Sinus Center, PLLC

Arun Kadambi, M.D.

1136 Monarch Street, Lexington KY 40513
859-223-0000 (phone) 859-223-0602 (fax)

Financial Policy and Payment Agreement

Thank you for choosing Allergy, Asthma & Sinus Center, PLLC. Please read and sign the following statements regarding our financial and insurance policies.

If you have health insurance, we will file your insurance claims. You must bring your insurance card, referral form (if applicable), and necessary co-payments/co-insurance to your appointment. Please understand that insurance is an agreement between you and your insurance carrier, and that we are not part of that agreement. We suggest you contact the customer service telephone number listed on the back of your insurance card to understand what your policy covers. Please be aware that we require a 24 hour notice for cancelled or rescheduled appointments.

We gladly accept cash, checks, credit cards and Care Credit. Should you need to discuss your bill, please contact our billing office at 859-223-0000. We are more than willing to work with you to resolve your balance; however, delinquent accounts will be referred to a credit bureau for collections.

Release of Information, Benefit Assignment, Payment Authorization, Full Disclosure Statement, Payment Agreement and Permission to Treat.

I hereby authorize Allergy, Asthma & Sinus Center to release any information necessary to my insurance company or billing agency to fulfill my financial responsibility. I authorize my insurance carriers to issue payments directly to Allergy Asthma & Sinus Center. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred. I agree to pay such fees in full. I have received a copy of the "Notice of Privacy & Policy Practices". I hereby give my permission to accept medical care by the providers and clinical staff of Allergy, Asthma & Sinus Center.

_____ _____

Patient/Responsible Party Signature Date

_____

Print Patient Name