PIENKOWSKI, M.D.
CLINIC
ALLERGY ASTHMA IMMUNITY

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NEW PATIENT PACK

We care for our community.

Knoxville
West Knox Plaza
7417 Kingston Pike,
Suite 101
Knoxville, TN 37919
(865) 584-4112
(865) 588-8140

Greeneville
1406 Tusculum Blvd.,
MOB 2, Suite 2500
Greeneville, TN 37745
(423) 638-9595
(423) 638-1527

Johnson City
Northside Professional Building
403 Princeton Road, Suite 4
Johnson City, TN 37601
(423) 928-0113
(423) 928-9405

Bristol
321 Midway Medical Park,
Suite 3
Bristol, TN 37620
(423) 968-3440
(423) 968-4948

Kingsport
2012 Brookside Drive,
Suite 11
Kingsport, TN 37660
(423) 378-3131
(423) 378-3400

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Welcome

Thank you for choosing Pienkowski, MD Clinic for your allergy, asthma, and immunity care.

We truly appreciate the trust you placed in us upon scheduling your first appointment.

Getting Ready For Your First Appointment

Date: **Time:**

V02

Patient Administrative Responsibilities

Your Insurance.

Get in touch with your insurance and take the following action:

- **Coverage.** Call your insurance company or check its website to verify your coverage for allergy and immunology services.
- **Verify.** Verify that Allergic Diseases, Asthma & Immunology Clinic, PC (the "Clinic") and the physician you plan to see is “in network.”
- **Ask.** Ask whether your insurance requires a referral from a primary care physician to see a specialist for allergy and immunology.

Complete all New Patient Paperwork (NPP). NPP includes the following items:

- **Patient Information Sheet.** Pay careful attention to each section. Specifically, make sure each of the following items are complete:
  - **Patient Information.**
  - **Insurance Information.** Please provide current insurance information.
  - **Referred by.** Please make sure to write the name of your referring physician.
  - **Responsible Party Signature/Date.** Do not forget to sign the Patient Information Sheet and date it.
- **Allergy and Immunology Questionnaire.** This questionnaire is two pages and requires the following:
  - **Accuracy.** Be certain to fill it out completely, as doing so will assist us in assessing your condition.
  - **Signature/Date.** Do not forget to sign/date the Allergy and Immunology Questionnaire.
- **Protected Health Information.** Carefully read this document as required by HIPAA. Print your name, sign, and date this sheet.
- **Payment Policy.** Print your name, sign your name, and date this form after carefully reading it.
- **Primary Care Physician Information.** Please fill out this section so we can be certain to communicate your progress to your primary care physician. In addition, let us know how you heard about us.

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- **Parental Release.** If you are bringing a child for treatment, print your child's name in the first paragraph. In addition, list the people who can get medical information about your child or bring your child in for treatment. Lastly, please sign and date the Parental Release.
- **Patient Information Release.** If you choose to allow Pienkowski, MD Clinic to speak with another person because they are involved in your care, please be sure to list those people on this sheet. In addition, sign and date the document.
- **Patient Cancellation Policy.** Please sign and date the Patient Cancellation Policy. Our Clinics have full schedules and would like the chance to offer an appointment that you cannot make to another person.

Required Personal Documentation. Please have the following items with you at your first appointment:

- **Insurance Card(s).** Bring your primary, and perhaps secondary insurance cards, to your visit. Be sure to notify us should your insurance information change.
- **Proper Photo Identification.** Proper photo identification includes a driver's license, passport, work ID, student ID, or the like.

Patient Medical Responsibilities

Restricted Medications Prior to Appointment. Do not take any of the following medications for **at least 3 days** prior to your initial appointment:

- **Antihistamines.**
- **Over-the-counter cold preparations.**
- **Steroids.**
- **Antibiotics.**

⚠ Taking any restricted medications will compromise the accuracy of your allergy evaluation. You may continue to use Inhalers and Steroidal Nasal Sprays.

List of Current Medications. Bring a list of all your current medication including:

- **Prescribed medications.**
- **Vitamins.**
- **Herbal Supplements.**

No Scented Products. Do not wear any cologne, perfumes, or body lotions. Such scented products are irritants, which my cause problems for other patients with breathing difficulties.

Comfortable Clothing. Please wear comfortable clothing including a top that can be easily removed for your examination.

Time.
Please allow a minimum of 1.5 hours for your initial evaluation.

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PATIENT INFORMATION FORM

Time: _____

Date: _____

Acct.#: _____
(For clinic use only)

Patient Information

Name: _____
Last Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Sex ◯ **M** ◯ **F** ◯ **Private**

Social Security: _____
Employer: _____
Business Phone: _____
Date of Birth: _____
Age: _____
Email: _____
Marital Status ◯ **S** ◯ **M** ◯ **W** ◯ **D**

Parent/Guardian Name(s) (If patient a child)**:** _____

Spouse Name: _____
Date of Birth: _____
Cell Phone: _____

Spouse Employer: _____
Phone: _____
Business Phone: _____

Emergency Contact Name: _____
Phone: _____
Relationship: _____

Insurance Information

Primary Please present insurance card to receptionist.
Insurance: _____
Policyholder Name: _____
Date of Birth: _____
Policyholder Address/Phone: _____
_____
Policyholder Employer: _____
Employer Phone: _____

Secondary Please present insurance card to receptionist.
Insurance: _____
Policyholder Name: _____
Date of Birth: _____
Policyholder Address/Phone: _____
_____
Policyholder Employer: _____
Employer Phone: _____

Authorization

I hereby authorize the Clinic to furnish any relevant information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered.
I understand that I am financially responsible for all charges whether or not covered by insurance. I agree to pay copays at time of service and all other insurance balances within 30 days of receiving a statement.

Responsible Party Signature: _____

Date: _____

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ALLERGY + IMMUNOLOGY QUESTIONNAIRE FORM

Part 1 of 2

Name: _____ Occupation: _____

Last Name: _____ Social Security: _____

Date of Birth: _____ Sex ◯ M ◯ F ◯ Private

Age: _____

For what sort of problem are you consulting the doctor?

◯ Hives ◯ Swelling ◯ Hay Fever ◯ Asthma ◯ Skin Problems
◯ Nasal Polyps ◯ Eczema ◯ Food Allergy ◯ Drug Allergy ◯ Eye Problems
◯ Ear Problems ◯ Drug Allergy ◯ Frequent Infections ◯ Sore Throat ◯ Headaches
◯ Immune Disorders ◯ Stinging Insect Allergy
◯ Other: _____

When did your condition begin? _____

Have you seen an allergist or other physician for this condition previously?

Doctor's Name: _____ Were you treated with medications?

When seen last? _____ ◯ No | Yes with _____

Were skin tests done? ◯ Yes ◯ No Were you treated with immunotherapy? ◯ Yes ◯ No

Were any skin tests positive? ◯ Yes ◯ No What kind? ◯ Injections ◯ Oral

Which months of the year is your condition worse?

◯ Jan ◯ Feb ◯ Mar ◯ Apr ◯ May ◯ Jun ◯ Jul ◯ Aug ◯ Sep ◯ Oct ◯ Nov ◯ Dec

Which of the following worsens your condition(s)?

◯ Yes ◯ No Indoors	◯ Yes ◯ No Nervousness	◯ Yes ◯ No Cosmetics	◯ Yes ◯ No Mushrooms
◯ Yes ◯ No Outdoors	◯ Yes ◯ No Eating	◯ Yes ◯ No Perms	◯ Yes ◯ No Wine
◯ Yes ◯ No At home	◯ Yes ◯ No Air Conditioning	◯ Yes ◯ No Newspapers	◯ Yes ◯ No Aspirin
◯ Yes ◯ No At work	◯ Yes ◯ No Barn area	◯ Yes ◯ No Wool	
◯ Yes ◯ No Morning	◯ Yes ◯ No Damp areas	◯ Yes ◯ No Road dust	◯ Chemicals (list):
◯ Yes ◯ No Afternoon	◯ Yes ◯ No Hay	◯ Yes ◯ No Milk	_____
◯ Yes ◯ No At night	◯ Yes ◯ No Mowing lawn	◯ Yes ◯ No Milk products	_____
◯ Yes ◯ No Weather change	◯ Yes ◯ No Dusty environment	◯ Yes ◯ No Wheat products	_____
◯ Yes ◯ No Rainy weather	◯ Yes ◯ No Air pollution	◯ Yes ◯ No Nuts, beans, seeds	_____
◯ Yes ◯ No Dry weather	◯ Yes ◯ No Animals	◯ Yes ◯ No Chocolate	_____
◯ Yes ◯ No Windy day	◯ Yes ◯ No Cooking odors	◯ Yes ◯ No Fish	◯ Drugs (list):
◯ Yes ◯ No Hot day	◯ Yes ◯ No Smoke	◯ Yes ◯ No Meat	_____
◯ Yes ◯ No Cold day	◯ Yes ◯ No Soap powder	◯ Yes ◯ No Fruit	_____
◯ Yes ◯ No Exercise	◯ Yes ◯ No Insecticides	◯ Yes ◯ No Vegetables	_____
◯ Yes ◯ No Sweating	◯ Yes ◯ No Paint fumes	◯ Yes ◯ No Beer	_____
◯ Yes ◯ No Anger	◯ Yes ◯ No Perfumes	◯ Yes ◯ No Cheese	_____

ALLERGY + IMMUNOLOGY QUESTIONNAIRE FORM

Part 2 of 2

About your living conditions:

Your home is:

- ◯ New ◯ Old
- ◯ Separate Home
- ◯ Apartment
- ◯ Trailer

Your heating is by:

- ◯ Radiators
- ◯ Stove
- ◯ Steam
- ◯ Space Heater
- ◯ Coiled Heat
- ◯ Forced Warm Air
- ◯ Built In
- ◯ Hot Water

Air Conditioning:

Home > ◯ Central ◯ Window

Work > ◯ Central ◯ Window

Your mattress is made of:

- ◯ Cotton
- ◯ Feather
- ◯ Foam
- ◯ Waterbed
- ◯ Horse Hair

Your pillow is made of:

- ◯ Feather
- ◯ Foam
- ◯ Kapok
- ◯ Dacron

List your pets (if any)**:**

_____

_____

Ever smoked regularly?

◯ No ◯ Yes: What kind?

◯ Cigarettes ◯ Cigars ◯ Pipe

Any air filter/purifier at home?

◯ No ◯ Yes

Is there a cellar in your home?

◯ No ◯ Yes

Is the cellar damp or mildewed/moldy?

◯ No ◯ Yes

Are you being treated for any other medical, surgical, or emotional condition?

◯ No ◯ Yes, explain: _____

_____

_____

Are you currently, or have you ever been treated for substance abuse?

◯ No ◯ Yes, explain: _____

_____

_____

Do you currently, or have you ever had any of the following:

◯ Glaucoma ◯ Cataracts ◯ Ulcers ◯ Lung Disease
◯ Thyroid Disease ◯ High Blood Pressure ◯ Heart Disease
◯ Blood Clots

What medications do you take regularly (prescription and over-the counter)**?**

_____

_____

What medications do you take occasionally (prescription and over-the-counter)**?**

_____

_____

_____

Using nasal sprays or nose drops (please list)**?**

_____

_____

Have you ever tested positive for tuberculosis? ◯ No ◯ Yes

Do any relatives have allergies?

◯ Mother ◯ Father ◯ Sister ◯ Brother

Others (specify)**:**

_____

_____

_____

❓ Referred by?

◯ Doctor ◯ Friend > Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

👉 Authorization

I hereby agree and understand that I am fully responsible for the bill for services rendered, regardless of any insurance coverage. I authorize payment directly to the physician.

Signature: _____

Date _____

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HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "Notice") from Allergic Diseases, Asthma and Immunology Clinic, P.C. d/b/a Pienkowski MD Clinic (the "Clinic") and that I have been provided an opportunity to review it. I understand that:

- I have certain rights to privacy regarding my protected health information.
- The Clinic can and will use my health information for purposes of my treatment, payment for treatment and health care operations.
- The Notice explains in more detail how the Clinic may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- The Clinic has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

Patient Acknowledgment

Name: _____

Date: _____

Signature: _____

Date of Birth: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgment Form

Name of Patient: _____

Date of Birth: _____

I attempted to obtain the patient's (or the patient's representative's) signature on the HIPAA Notice of Privacy Practices Acknowledgment Form, but was unable to do so as documented below:

_____

_____

Name: _____

Date: _____

Signature: _____

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PAYMENT POLICY FORM

Our primary purpose is to provide you with the best medical care available. We thank you for the confidence you have shown in our clinic by choosing us for your healthcare needs.

We make every effort to keep your medical costs down. You can also help in this effort by paying upon completion of each visit. This eliminates billing costs, which are unrelated to good medical care.

NOTE: All copays are due at the time of your visit. We accept cash, check, debit and credit cards.

We file your insurance as a courtesy to you, our patient. However, we cannot accept the responsibility for collecting your insurance claims or for negotiating settlement on your claims. Your insurance is a contract between you and your insurance company.

Please initial the following statement related to the payment of your medical bills:

_____I will pay my copay and any additional amounts due at the time of each visit.
(Initials)

The above policy does not apply to those patients covered by an insurance plan with which we have a contractual obligation to file insurance and with whom we are a in network.

We do file Medicare claims as required by law. However, you are expected to pay any co-pay, coinsurance or deductible according to your individual insurance policy.

If you are unable to meet your financial obligations, we offer financing through Care Credit. In the event your account is 90 days past due, your account will be turned over to a collections agency.

I have read the above information and understand my responsibilities for payment.

Patient/Guardian Acknowledgment

Name: _____

Date: _____

Signature: _____

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PRIMARY CARE PHYSICIAN INFORMATION FORM

How did you hear about us?

We strive to help as many sufferers as possible and reaching them is important to us.

- ◯ **Web search / Website**
- ◯ **Facebook**
- ◯ **Knoxville Kids' Directory**
- ◯ **YMCA**
- ◯ **Go Tri Cities**
- ◯ **Billboard**
- ◯ **Yellow Pages**
- ◯ **Current Patient**
- ◯ **Family/Friend**

◯ **Referring Physician:**

Dr _____

_____

Nurse Practitioner (Name)

_____

_____

Physician Assistant (Name)

_____

_____

Primary Care Physician

Patient Name: _____

Physician Name: _____

Group or Business Name: _____

_____

Physician/Group Address:

Street: _____

City: _____

State + Zip: _____

Physician Phone: _____

Physician Fax: _____

PARENTAL RELEASE FORM

I authorize this clinic: Allergic Diseases, Asthma and Immunology Clinic, P.C. d/b/a **Pienkowski, M.D. Clinic** (the "Clinic") to administer medical treatment to my child:

_____

(First and Last Name)

without my presence, which includes (but is not limited to) allergy injections.

However, I acknowledge that I must be present for any scheduled appointments my child has with any physician or nurse practitioner.

In addition, the people listed to the right may obtain health care for my child at the Clinic in case of my absence. I understand that anyone NOT listed on this sheet, regardless of relationship to my child, will NOT be allowed to obtain health information or bring my child into this clinic for his/her allergy injections or appointments.

Authorization

Name (print)**:** _____

Relationship: _____

Name (print)**:** _____

Relationship: _____

Name (print)**:** _____

Relationship: _____

Signature of Parent and or Legal Guardian

_____

Date: _____

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RELEASE OF PROTECTED HEALTH INFORMATION FORM

Patient Name (print)**:** _____

Date: _____

I give permission to the physicians and staff at Allergic Diseases, Asthma & Immunology Clinic, P.C. d/b/a **Pienkowski, M.D.** Clinic , to discuss my protected health information with the following people I have listed below.

List family members and/or friends whom you permit to have access to your health information because they are involved in your care or payment related to your healthcare.

Authorization

Name (print)**:** _____

Relationship: _____

Phone: _____

Name (print)**:** _____

Relationship: _____

Phone: _____

Name (print)**:** _____

Relationship: _____

Phone: _____

Patient Signature: _____

Date: _____

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PATIENT CANCELLATION POLICY FORM

We strive to provide nothing but excellent patient care. Patient satisfaction and wellbeing is our ultimate concern. In order to provide high-quality service to all new and established patients, it has become necessary to establish a patient cancellation policy.

Patients are obliged to attend their scheduled appointments. When you miss an appointment without advanced notice, the Clinic never even gets the chance to offer that appointment time to another patient in need of treatment.

We understand that you may need to miss a scheduled appointment from time to time.
Just do us a favor and give us **at least 24 hours notice** if you must cancel your appointment. Giving us advanced notice will allow the Clinic to offer that appointment time to another patient.

Should you need to cancel an appointment after the office is closed – weekends and holidays, inclusive – we request that you call the office and leave a message.
Otherwise, please make appointment cancellations during our regular business hours.

If you miss an appointment without 24 hours notice, there will be a fee assessed. This fee will be due when you are billed or at your next appointment, whichever event comes first. This fee is the sole responsibility of the patient and will not be billed to your insurance company.

THE MISSED APPOINTMENT FEE IS $20.00

If you have an unavoidable emergency pop up, please let us know as soon as possible. We have no intention of punishing patients with a missed appointment fee for emergency situations entirely out of their control.

In order to better serve you, we have an automated appointment reminder system in place. Our hope is that the automated reminder will help everybody keep their appointments and receive the care they need. Please be sure to specify a contact number at which you check messages regularly.

We sincerely thank you for working with us to provide you the best possible care.

I acknowledge that I understand the meaning and purpose of the above information.

Patient/Guardian Acknowledgment

Name (print)**:** _____

Patient Signature: _____

Date: _____