Allergy Testing NP Paperwork

1. Patient Information

Last Name: | First Name: | M.I. | DOB:

Gender: | Race: | SSN: | Ethnicity:

Address: | City: | State: | Zip:

Phone: | Email: | Language:

Marital Status
○ Single ○ Married ○ Partner ○ Divorced ○ Widowed

Employment Status
○ Employed ○ Unemployed ○ Retired ○ Student

2. Referring Physician:

Primary Care Physician: | Practice Name:

Address: | City: | State: | Zip:

3. Emergency Contact Information:

First Name: | Last name:

Phone: | Relationship to Patient:

4. Insurance Information:

Carrier Name: | Group#: | ID#:

Guarantor's First Name: | Last Name: | M.I.

Guarantor's SSN: | DOB: | Relation to Patient:

Guarantor's Employer Name:

Address: | City: | State: | Zip:

Business Phone:

5. Additional insurance (if any):

Carrier Name: Group#: ID#:

Guarantor's First Name: Last Name: M.I.

Guarantor's SSN: DOB: Relation to Patient:

Guarantor's Employer Name:

Address: City: State: Zip:

Business Phone:

6. Please upload front and back of Insurance Card and front of Drivers License.

7. Provide Payment Card information

Allergy & Asthma Specialists of Kansas City

Payment Card Agreement

Patient Name _____

Date of Birth _____

It is the policy of Allergy & Asthma Specialists of Kansas City to have a payment card (credit or debit) on file for ALL patients. If you do not provide a payment card, you will not be seen.

1. All patient visits will first be charged to your designated insurance carrier for services rendered. If your insurance claim comes back with a patient responsibility balance such as co-insurance, deductibles or non-covered services etc., you will receive a statement. You will have 30 days from the statement date to pay your balance in full. All or any remaining balances will then be charged to the card on file. If you pay your bills by the due date, your card will not be charged. If you would like to use the card on file to pay your bill, do nothing and the card will be charged.

2. Any charges related to no shows, late cancellations will be charged directly to your card on file without any waiting period or statements sent. Same policy will be applicable in case your insurance does not validate in our system with a co-pay responsibility, but later processes with a co-pay, the card on file will be charged for the co-pay without any waiting period or statements been sent.

3. All cards will be stored electronically in the Payment Card Industry Compliant & Cyber Security Insured system which sets rules to minimize risks of data breaches on all accounts, truncating card information and keeping consumer's data safe and private when payments are taken and stored. Your card on file can only be used to pay account balances incurred at our office, through our secured payment terminal.

4. It is YOUR responsibility to notify us of any change to your insurance so that we can submit the charges to your carrier in a timely manner. It is also YOUR responsibility to notify us if there is any change to your card on file so that the information can be updated. If your card is declined for any reason and we cannot collect payment, you will be subject to a **$25 fee**. In this case, we reserve the right to refuse further medical treatment and will dismiss you from the practice as it is a violation of our billing agreement. Furthermore, your account will be handed over to collection agency to assist with collection of balance on your account.

You, the Patient/Parent/Guardian/Co-Signer, by signing this agreement, agree to allow Allergy & Asthma Specialists of Kansas City to utilize your credit or any other payments card as provided by you to pay all fees and costs due to Allergy & Asthma Specialists of Kansas City at any time if money is owed after your primary insurance carrier has been billed or from amounts excluded from your insurance (i.e., Cancellation/No Show fees/Co-pays). You also certify that you are the authorized user of the card and that you will not dispute the payment with your card company so long as the transaction corresponds to the terms indicated in this agreement. Your signature indicates your understanding and compliance with fore-mentioned policies.

Parent/Guardian Name (in case of a minor) _____

Name on the card _____

Last 4 digits of Payment Card _____

Expiration Date _____

_____ _____

Client Signature Date

Allergy & Asthma Specialists of Kansas City

2727 NE Brooktree Lane

Gladstone, MO 64118

Financial & Office Policies

- **Authorization to Treat:** I authorize the physicians/providers of Allergy & Asthma Specialists of Kansas City (AASKC) to render any necessary treatment. In case of minor children, AASKC is providing care under the assumption that the person bringing the child to the office has been authorized by parent/guardian to bring the patient in for care, therefore, authorizing Protected Health Information (PHI) to be shared with the person accompanying the child. This will remain in effect from this date forward unless "written" revocation of such.
- **Authorization to release information and Assignment of Benefits:** I authorize the physician to release any information acquired in the course of treatment necessary to process insurance claims.
- **Authorization to pay benefits to Physician:** I authorize payment directly to the physician for the surgical and/or medical benefits, if any, otherwise payable to me; for services rendered.
- **Insurance Plan:** I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen at "out of network" benefits. It is my responsibility to confirm coverage of services with my insurance carrier prior to my visits. I agree to be responsible for all copays, deductibles, co-insurance and non-covered services determined by my insurance plan. I am responsible for providing AASKC with any updates to my insurance. If any charges are denied due to not providing current insurance information, I understand that I will be responsible for the unpaid balance.
- **Referrals:** If my insurance plan requires a referral for me to be seen at AASKC office, it is my responsibility to arrange for one from my primary care physician/referring provider.
- **Check In:** Co pays and past due balances are due at the time of check-in. Please come prepared to pay. In case of minor children, regardless of who brings the child in for patient services, payment is expected. Payment collection will not be delayed for any reason. If you do not have your copay or have not come prepared to pay past due balances, your appointment may be rescheduled for a later time so that you may meet your obligation. Please also bring your current insurance card and driver's license with you at each visit. For all visits we will ask you to verify insurance and demographic information so that our records remain current. If you are a self-pay patient, 100% of the fees are due at the time of check-in.
- **Payments:** I guarantee that I will promptly pay all amounts that have been determined to be my responsibility upon receipt of my statement. I understand that my health insurance contract is between my insurance company and myself and AASKC is not a party to it. Any balance remaining after my health insurance pays, denies or deems non-covered under my plan will be my responsibility. If my insurance does not pay for the services rendered by the practice; the practice will look to me for payment. The practice agrees to refund any over payment that I have made on my account in the event that my insurance eventually pays. All payments will be applied to satisfy the oldest balance first. Payment forms accepted include cash, check, debit, credit, HSA and FSA cards.
- **Payment Card on File:** All patients are required to leave a payment card on file with our office (please refer to "Payment Card On File Agreement" for details). If you do not provide a payment card, you will not be seen.
- **Returned Check:** All checks that are Returned Checks/Insufficient Funds will have an additional $35 charge added to the account.
- **Collections:** If I have not paid my bill or have not arranged for a payment plan, the practice will ask for the assistance of an outside collection agency. If my account is turned over to a collection agency,

I will be dismissed from the practice. A 30% collection charge will be added to cover the collection fees. In order to collect any amounts I owe, I allow AASKC's representatives, ancillary providers, HIPAA business associates, vendors, and debt collection agency staff to contact me.

- **Office Behavior:** Our mission at AASKC is to have a relationship with our families of mutual respect. Should a concern or serious issue arise it is best to contact our Practice Administrator or Nurse Manager. Confrontational behavior toward AASKC employees whether it is in person or on the phone can be basis for dismissal from the practice.
- **Appointments & Late Arrivals:** We ask you to arrive on time to your appointment. If you are more than 15 minutes late you may be rescheduled.
- **No Shows:** Patients who do not keep their appointments deprive others of an opportunity to see their doctor. Please call us as soon as you know that you will not be able to keep an appointment. We charge $88 no show fee for new appointments and $45 for follow- up appointments. If an appointment is cancelled with less than 24 hours of advance notice or the patient simply does not show for the appointment, no show fees will be charged to the patient. This fee is not covered by insurance. Three no shows or same day cancellations will result in termination from our practice.
- **Forms:** There is a charge for requesting various forms/medical records by the patients. Please ask for fee schedule at the front desk.
- **Notice of Privacy Practices (HIPAA):** I understand the Notice of Privacy Practices documents that are made available to me regarding HIPAA. I understand that I have the right to ask for a complete copy of these documents for evaluation at any time.

Patient Name: _____

DOB: _____

Name of Parent/Guardian (if signing on behalf of minor patient):

_____

By signing below, I acknowledge understanding of all of the policies listed above and agree to comply with them

_____ _____

Client Signature Date

Allergy & Asthma Specialists of Kansas City

2727 NE BROOKTREE LANE

Gladstone, MO 64119

816-453-7771

Permission to Disclose Information to Those Involved in My Care

This form does not authorize releasing copies of my medical records.

I hereby allow Allergy & Asthma Specialists of Kansas City to disclose the following information:

Check all that applies:

☐ Appointment dates and times

☐ Medical information, including my symptoms, diagnosis, test results, medications and treatment plan

☐ Billing/Payment information

☐ Other health information (describe): _____

To the following people who are involved with my health care and/or payment information:

Check all that applies and list names and phone numbers:

☐ Spouse/Partner: _____

Phone: _____

☐ Friend: _____

Phone: _____

☐ Children: _____

Phone: _____

☐ Other: _____

Phone: _____

Can confidential messages be left on your answering machine or voicemail?

Check all that apply.

☐ No, DO NOT leave messages

☐ Yes

I understand that in certain situations Allergy & Asthma Specialists of Kansas City could speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permission at any time.

Patient Name: _____

Date of birth: _____

If patient is a minor, please complete the following information:

Mother's name: _____

Contact number: _____

Father's name: _____

Contact number: _____

_____ _____

Client Signature Date

SKIN TESTING DRUG GUIDELINES

DIAGNOSTIC SKIN TEST CANNOT BE DONE IF PATIENTS ARE TAKING THE FOLLOWING MEDICATIONS

You must consult with referring physician prior to stopping any medications

Medications to Withhold	Length of Time to Withhold
Topical anti-inflammatory or steroids (creams, lotions, gels, ointments, or Solutions)	Do not apply the morning of test
Long-lasting antihistamines Cetirizine (Zyrtec), Fexofenadine (Allegra), Desloratadine (Clarinex), Levocetrizine (Xyzal), Loratadine (Claritin), Hydroxyzine (Atarax.Vistaril)	Withhold 7 days prior to testing
Other antihistamines Actifed (Chlorpheneramine), Dimetapp (Brompheniramine) And Benadryl (Diphenhydramine)	Withhold 5 days prior to testing
Nasal and eye medications Patanase/Pataday/Patanol/Alaway (Olopatadine, Astepro/Optivar/Astelin/Dymista (Azelastine), Ryaltris	Withhold 2 days prior to testing
Biologics Xolair (Omalizumab)	Withhold for 6 months prior to test
Miscellaneous Zantac (Ranitidine), Pepcid (Famotidine) and Tagamet (Cimetidine)	Withhold for 2 days prior to test
Psychiatric Medications Amitriptyline (Elavil), Clomipramine (Anafranil), Desipramine (Norpramine), Doxepin (Sinequan), Imipramine (Tofranil), Notriptyline (Pamelor), Protriptyline (Vivactil), and Trimipramine (Surmontil) have antihistaminic activity	Withhold for 2 weeks prior to test
Nausea Medications Promethazine Dramamine (Dimenhydrinate)	Withhold 5 days prior to test
Sleep Medications Trazadone	Withhold for 3 days prior to test
Muscle Relaxants Flexeril (Cyclobenzaprine)	Withhold for 2 weeks prior to test
Other Buspar, Mirtazapine, Quetiapine	Withhold for 2 days prior to test

This list is not exhaustive and may not include all medications. If there are any questions whether or not you are using an antihistamine, you may ask your referring doctor or one of our allergists. In some instances, a longer period of time off these medications may be necessary. If the condition requires continuous administration of any of the above medications, or if you have a question about a certain medication, please notify us so we may discuss this and determine whether alternative tests are indicated.

THE FOLLOWING MEDICATIONS CAN BE TAKEN PRIOR TO SKIN TESTING

Nasal Steroids
Xhance, Flonase/Veramyst (fluticasone), Rhinocort (Budesonide), Nasonex (Mometasone), Nasacort (Triamcinolone), Nasarel (Flunisolide)

Leukotrient Receptor Antagonists
Singulair (Montelukast)
Accolate (Zafirlukast)

Asthma Inhalers
Any/all asthma inhalers and nebulizers

Patient Instruction Sheet for Allergy Skin Testing

Skin Test: Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a welt or hive with surrounding redness). The results are read at 15 to 20 minutes after the application of the allergen. The skin test methods are:

Prick Method: The skin is pricked with a very short needle coated with a drop of allergen (e.g ragweed pollen).

Intradermal Method: This method consists of injecting small amounts of an allergen into the superficial layers of the skin.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

You may be tested to important (location) airborne allergens and possibly some foods. These may include trees, grasses, weeds, molds, dust mites, animal dander, and some foods. The skin testing generally takes 45 minutes. Prick (also known as percutaneous) tests are usually performed on your back but may also be performed on your arms. Intradermal skin tests may be performed if the prick skin tests are negative and are performed on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes and, typically, no treatment is necessary for this itchiness. Occasionally, local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious, do not indicate a meaningful allergy, and will disappear over the next couple days or so. They should be reported to your physician at your next visit. You may be scheduled for skin testing to antibiotics, local anesthetics, venoms, or other biological agents. The same guidelines apply.

Skin testing will be administered at this medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances.

Please let the physician and nurse know if you are:

1) Pregnant as allergy testing may be post-poned until after pregnancy.
2) Taking beta blockers, medications that may make the treatment of the reaction to skin testing more difficult.

Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available. After skin testing, you will consult with your physician, who will make further recommendations regarding your treatment

Please do not cancel your appointment since the time set aside for your skin test is exclusively yours. If for any reason you need to change your skin test appointment, please give us at least 24 hour notice, due to the length of time scheduled for skin testing, a last minute change results in a loss of valuable time that another patient might have utilized.

Recommendations from Allergy diagnostic testing: an updated practice parameter /2008)

Updated 05/09/2024