THE ALLERGY & ASTHMA CENTERS OF CAPE COD

Health Questionnaire

Name:_____ **Date of Birth:**_____

Referred By:_____ **Date of Appointment:**_____

Briefly describe what you want to accomplish at your visit.

_____

_____

_____

_____

_____

Nasal Symptoms. Underline your symptoms. Circle the most bothersome.

sneezing	itchy nose	runny nose	itchy palate	itchy eyes
stuffy nose	sinus pressure	post-nasal drip	clogged head	headaches
snoring	no smell	sinus infections	sore throat	ear infections

age at onset: ____ stable _____ worsening _____ improving _____

symptoms are worse: inside / outside home / work morning / night

How severe is your nose problem? mild _____ moderate _____ severe _____

Underline the months that symptoms are present. Circle the worst months.

J F M A M J J A S O N D

Chest Symptoms. Underline your symptoms. Circle the most bothersome.

wheezing	day cough	night cough
exercise cough	chest tightness	throat tightness
shortness of breath	frequent infections	increased sputum

age at onset: _____ stable _____ worsening _____ improving _____

symptoms are worse: inside / outside home / work morning / night

How severe is your chest problem? mild _____ moderate _____ severe _____

number of hospital admissions this year: _____ number of ER visits this year: _____

number of attacks not requiring ER: _____ days per week with symptoms: _____

days of missed school/work this year? _____ nights awakened per month: _____

Do you need to limit activities? _____ chest x-ray/CT scan: _____

Underline the months that symptoms are present. Circle the worst months.

J F M A M J J A S O N D

(over)

Name:_____

Skin Symptoms. Underline your symptoms. Circle the most bothersome.

hives	swelling	eczema
itching	other rash	

Current treatments for your problems. How well do they work?

_____ _____

_____ _____

_____ _____

Triggers. Do you recognize things that worsen your symptoms?

trees	grass	weeds	mold	dust	animals
infections	exercise	cold	heat	humidity	wind
laughter	pollution	strong odors	aerosols	liquor	stress
eating	menses	cigarettes	make-up	food	other: _____

Medical History. What other illnesses do you have and what do you take for them?

_____

_____

drug allergies: _____

food allergies: _____

Review of systems. Do you have any other bothersome symptoms?

fever	weight loss	joint swelling/pain	stomach problems
palpitations	burping	hormone problems	heartburn
bowel problems	bladder problems	anxiety/stress problems	

Family history. What illnesses run in your family?

hay fever	sinus problems	asthma	headaches	hives
swelling	emphysema	eczema	other: _____	

Social History.

marital status: _____ occupation: _____

grade in school: _____ children/siblings: _____

Environmental survey. Are there things at work or home that cause your symptoms?

cats	dogs	rabbits	other pets
musty odors	basement bedroom	basement playroom	smokers
water problems	horses		

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PATIENT INFORMATION FORM

Please print and complete all sections.			**Today's Date:** _____
Patient's Name:		DOB:	☐ F ☐ M
Mailing Address:			
City:	State:	Zip Code:	
Home Phone:		Work Phone:	
Cell Phone:		Best # to reach you during the day: ☐ Cell ☐ Home ☐ Work	
Email Address:		Your email is protected by and only used by Allergy & Asthma Centers of Cape Cod	
Social Security #:		Marital Status: ☐ M ☐ S ☐ D ☐ W	
Occupation:	Employer:	Phone:	
Name of Person Responsible for Account:			
Primary Care Physician (PCP):		Phone:	
Preferred Pharmacy Name:		Preferred Pharmacy Phone:	
Emergency Contact Name:			
Phone:		Relationship:	
Race/Ethnicity: ☐ African American ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Caucasian ☐ Mexican American ☐ Other:_____ ☐ Decline to state Ethnicity:_____			

Pediatrics: If Patient is a child, or a dependent on parent's health insurance plan, please complete the following information.		
Parent Name: ☐ Father:	☐ Mother:	Phone:
Name of Employer & Work Address (if different from above):		
Parent's DOB: Mother:	Father:	

Insurance:			
Primary Insurance Company:			
Insured's Name:		Relationship to Patient: (If not self)	
ID#:	Group#:	Insured's SSN:	Insured's DOB:
Secondary Insurance Company:			
Insured's Name:		Relationship to Patient: (If not self)	
ID#:	Group#:	Insured's SSN:	Insured's DOB:
Please tell us how you heard about our practice?			
☐ Physician: Name_____ ☐ PCP ☐ Specialist ☐ Ins. Company ☐ Pharmacy			
☐ AACCC Patient: _____ ☐ AACCC Employee: _____			
☐ Our Website ☐ Web ☐ Yellow Pages ☐ Advertisement:_____ ☐ Other:_____			

I authorize payment of insurance benefits directly to The Allergy & Asthma Centers of Cape Cod or supplier for these services. I authorize the release of any medical information necessary to process all insurance claims. I understand that co-payments, deductibles, co-insurance & fees for services not covered by my insurance are my responsibility. I understand that I am responsible for obtaining, & keeping current, referrals from my Primary Care Physician if required by my insurance plan & that I am financially responsible for any additional charges that occur if the necessary referrals are not provided. If my insurance denies payment or I have no insurance, I understand that I am financially responsible for all charges. By signing this document I state that all information given is current and accurate.

Signature_____ **Relationship to Patient** _____ **Date**_____

Patient or person authorized to consent for patient (If signing for a minor)

THE ALLERGY & ASTHMA CENTERS OF CAPE COD

HIPAA NOTICE OF PRIVACY – PATIENT ACKNOWLEDGMENT

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Federal Government has required that your medical records remain private, confidential and absolutely not available to anyone without your expressed written consent. Our medical record of your care remains the physical property of The Allergy & Asthma Centers of Cape Cod (AACCC). Forms are available to you that will allow you to authorize, in writing, the release of a copy of specific parts of your medical records to another physician or medical practice.

Health Care Operations

There remains certain instances where, in the process of delivering good medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals employed by AACCC, without expressed written permission of each and every specific incident by you. Some examples include:

- Requesting your photo ID at every visit
- Faxing, calling, or electronically communicating to your pharmacy for medication renewal or authorization
- Calling your insurance carrier for billing and/or reimbursement purposes
- Faxing your insurance with documentation of care
- Faxing, calling, or emailing your Primary Care Physician (PCP) with results of care or questions
- Handling of the mail, newsletters, claims, bills, referrals
- Leaving a reasonable and limited message on the following; email or your home, work and/or cell voicemail/text
- Office medical staff informing you of healthcare results or possible treatment options
- Transcription of letters, consults, test results, progress notes, appointment reminders, etc., within the practice
- The office/reception staff calling, texting, or emailing you to schedule an appointment, acquire a referral or to inform you about medication that may have to be stopped prior to testing at an office visit
- Verbal or written correspondence with insurance companies; yours and ours
- Discussing (verbal and written) complex evaluation and management of your healthcare with peers and/or experts in medical care
- Routine inter-office communication between professional staff of this specialty practice to effectively manage your medical care, and with the administrative staff to coordinate referrals, send/call appointment reminders, file & store medical records, order/receive antigen, submit claims and manage accounts, billing and co-pays
- Private Health Information (PHI) utilized for staff training
- PHI utilized to improve office practices and/or for compliance reviews

You may restrict disclosure of any part of your Private Healthcare Information from within this practice to any outside source or recipient, where not allowed by law: Federal, State, or by Court Order.

Your Rights Under the Law

- You have the right to receive a notice about our privacy policy
- The right to inspect your protected health information (PHI) with a provider in a private environment
- The right to request a copy of PHI and to have it returned to you in 30 days, unless notified in writing
- The right to request to receive confidential communications from the practice by alternative means or at an alternative location
- The right to request an amendment of your PHI
- The right to revoke or limit authorization
- The right to be notified of a breach of your PHI

Please list by name and relation the person(s) that may receive messages or talk to us regarding your medical care.

Name/Relation	Contact Number
Name/Relation	Contact Number
Name/Relation	Contact Number
Name/Relation	Contact Number

It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a "needs to know" basis, and then kept confidential for your assurance that we comply with the Federal, State, and local laws on "Confidentiality of Medical Information."

ACKNOWLEDGMENT

I, _____ (patient or responsible party), acknowledge that I have received a copy of The Allergy & Asthma Centers of Cape Cod (the practice's) "HIPAA Notice of Privacy - Patient Acknowledgment " document regarding protection of Personal Health Information (PHI).

Patient's or Responsible Party's Signature	Date

Please Note: You may at any time request a detailed written policy of the Allergy & Asthma Centers of Cape Code's "HIPAA Privacy Notice-Detailed".

THE ALLERGY &
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OF CAPE COD

PATIENT MEDICATION LIST

(Please include all prescription medication as well as,
over-the-counter medication, vitamins, herbs and all supplements)

Patient:_____ DOB:_____ Date:_____

Drug Name	Dose	Directions	To Treat?	Quantity/Supply	Prescribing Dr

THE ALLERGY &
ASTHMA CENTERS
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Acknowledgment of Financial Policy

Thank you for choosing The Allergy & Asthma Centers of Cape Cod (AACCC). We want all of our patients to have a good understanding of our practice's financial policies. Please review the following information and if you have any questions, don't hesitate to call our office. We accept cash, checks, and all major credit cards. **Insurance**

- I understand that it is my responsibility to pay any portion of services not covered by my health insurance. I acknowledge that it is my responsibility to verify my insurance coverage prior to my appointment. AACCC may inquire as to my benefits and eligibility on my behalf. I understand that benefits quoted by my insurance to AACCC staff are NOT a guarantee of payment. I will be responsible for any remaining balance that is not covered by my carrier regardless of quoted benefits.
- I agree to provide The Allergy & Asthma Centers of Cape Cod all insurance information, including primary and secondary and to have my current insurance card(s) available at every visit. Additionally, a photo ID is required for new patient visits. I acknowledge that it is also my responsibility to notify the practice of any changes to my insurance coverage prior to my scheduled appointments. If I do not notify the practice of such change(s) in my coverage or the effective date of any new insurance, I acknowledge that I am responsible for any charges that are not covered.
- I am responsible for any co-payments, deductibles, co-insurance and non-covered service fees. Co-payments are due at the time of service. The co-pay requirement cannot be waived. The parent/legal guardian bringing a child in for visits will be responsible for the co-pay. If an inquiry into my eligibility shows an unmet deductible and co-insurance, the practice will collect such at the time of my appointment.

Referrals - It is my responsibility to obtain any necessary referrals and to maintain referrals as my insurance requires. I understand that AACCC may choose not to provide me services if a current referral is not in place prior to my visit. I understand that I am responsible for any charges that my insurance company may not pay as a result of my failure to obtain the necessary referrals/preauthorizations.

Payment – All patient balances are due in full upon receipt of our summary statement each month, unless a formal payment plan is established with the practice. Any payments received on account will be applied to the oldest balance first. I understand that, if I have a balance due at the time of a scheduled appointment, payment will be due at the time of service unless a formal payment plan has been established with the practice. **Missed Appointments –** Broken appointments negatively impact other patients on our waitlist who could have been seen at the appointment time we reserved just for you. We ask that you please be considerate of this if you need to reschedule your appointment. To this end, our practice requests a minimum of one full business day's notice for cancellations. I understand that if I have a late cancel or missed appointment I may be charged a cancellation fee of $75.00. Excessive late cancellations may result in discharge from the practice. **Returned Checks & Refunds-** I will be charged a $75.00 fee for any returned checks. Credits in amounts less than $10.00 will be retained on account to be credited toward future balances unless a refund is requested. **Minor Patients -** If I am the parent or legal guardian of a minor patient I am responsible for payment of the account as outlined above. AACCC will not be involved in divorce disputes.

I understand and agree to the above Financial Policy of The Allergy & Asthma Centers of Cape Cod.

_____ _____ _____ Patient

(Responsible Party) Printed Name Patient (Responsible Party) Signature Date