Allergy & Asthma Specialists of Michigan

43417 Schoenherr Road
Sterling Heights, MI 48313

Phone: 586.981.0390
Fax: 586.803.3512

www.aasmich.com

Angela M. Iacobelli, M.D.
Darlene Brown, MSN, RN, NP-C

Patient Registration

Full Patient Name: _____ Date: _____/_____/_____
(First) (Middle) (Last)

Sex: M____F____ DOB: ____/____/____ Age: _____ Marital Status: Single Married Widowed Divorced Separated

Address: _____
(Street) (City) (State) (Zip)

Telephone: Home: _____ Cell: _____ Work: _____

Email address:_____
Employed by:_____ Employer Address:_____
Occupation:_____ Preferred method of contact: Phone____ Email____ Other_____
Primary Care Physician: _____ Phone: _____
PCP Address: _____
Referred by: Physician____ Self____ Family ____ Friend____ Internet____ Insurance Company____
Referred by: _____
(List name of the person who referred you; if referred by a doctor who is not your primary care doctor list name and address)
Emergency Contact: _____ Phone:_____ Relationship:_____

Insurance Information:
Primary Insurance: _____
Subscriber Name:_____Subscriber Date of Birth:_____
Relationship to patient: _____ Group #_____ Contract #_____
Subscriber's Employer: _____

Secondary Insurance:_____
Subscriber Name:_____Subscriber Date of Birth:_____
Relationship to patient: _____ Group #_____ Contract #_____
Subscriber Employer: _____

Financial Authorization:
We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company requires an authorization or referral, it is the patient's responsibility to obtain this for the initial visit and for continuation of care.

I hereby authorize the office of Allergy & Asthma Specialists of Michigan to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payer to pay directly to Allergy & Asthma Specialists of Michigan for services rendered. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

Print Name/Signature _____ Date_____
Print Name/Signature Patient/Parent/Guardian

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Pediatric Form

For Pediatric Patients:

Who does the patient live with? _____ Relationship to the patient: _____

Mother/guardian name: _____ Contact Phone: _____

Address (if different than above): _____

Father/guardian name: _____ Contact Phone: _____

Address (if different than above): _____

Permission to treat minor when parent/guardian not present

I, _____ the parent/guardian of _____, give Asthma & Allergy Specialists of Michigan to treat my child when not accompanied by a parent or guardian. This request shall be voided upon written request.

Signature: _____ Date: _____

Pediatric patients only (Circle the following items and fill in information as indicated):

Child lives with:	Both parents/Guardian(s) Parents are divorced
Schooling:	Grade level:
Does the child attend daycare:	Yes No If yes: Full time Part time
Does the child have siblings:	Yes No If yes, how many: _____
Birth/Developmental history:	Child was born: Premature Full term Child had prolonged hospitalization: Yes No Breast Fed: Yes (#months ____) No Feeding difficulties: Yes No Recurrent infections: Yes No LATE on immunizations: Yes No ABNORMAL growth/development: Yes No

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Financial Policy

Thank you for choosing Allergy and Asthma Specialists of Michigan as your allergy and asthma provider. We are committed to building a successful physician-patient relationship with you and providing you with the best quality of care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Please ask if you have any questions about our fees, policies, or your responsibilities. The following is a summary of our financial policies, an explanation of your responsibilities, and authorization to bill your insurance on behalf of the services provided.

- You are financially responsible for any services performed by our providers that are not covered by your insurance policy. Services may not be a benefit of your health care insurance plan. We strongly suggest you contact your insurance company to determine if services rendered by our office are a covered benefit under your insurance policy. If you need assistance in obtaining this information, we will be glad to help you.
- All copays, and past due balances are due at check-in prior to seeing the provider for a visit and/or prior to receiving any future services including allergy extract and injections.
- You are financially responsible for any copay, deductible, or coinsurance which is an amount determined by your specific insurance policy. Payments including copays, are due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express, and Discover. A fee of $50.00 will be charged for returned checks. Balances greater than 60 days will be subject to additional fees. There will be an additional $5.00 monthly fee added to each patient's statement for balances that are greater than 60 days overdue. If any balance on your account is over 90 days past due, your account will be in default and reported to a collection agency. An additional late fee of $35.00 will be added to accounts that are 90 days past due.

  Please note: A 50% fee will be charged on any accounts that are sent to collections in addition to the outstanding charges to cover the collection agency fees.
- We realize that temporary financial problems may affect the timely payment of your account. If such problems arise, we encourage you to contact our office immediately for assistance in management of your account.
- Your insurance is a contract between you and your insurance company. We will bill your primary insurance as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance as well as any change in name, address, or insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill.
- If your insurance company is not contracted with us, you will be responsible for payment in full. However, as a courtesy our billing office will file your initial insurance claim. If it is not paid in full after 60 days, you will be responsible.
- If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.
- If your insurance plan requires that you obtain a referral form your Primary Care Provider (PCP) before visiting a specialist, YOU ARE RESPONSIBLE for obtaining the referral. Failure to obtain the referral may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if a proper referral is not obtained.
- Divorced parents: The parent/guardian who was granted primary custody is responsible for payment of copays & deductibles at registration. If a divorce decree states medical expenses are shared, the custodial parent/guardian will be billed for the full amount and is responsible for obtaining their own reimbursement of the shared expense from the non-custodial parent.
- Please understand that when you reserve an appointment with one of our providers, that we are making a commitment to your medical care and this prevents another patient from receiving care at that time. Please provide our office with a 24-hour notice for appointments you wish to cancel or reschedule. Appointments that do NOT get canceled/rescheduled within 24 hours of the appointment time will result in a $50.00 cancellation fee.

<u>Patient/Responsible Party Statement</u>:

I understand a statement of my charges and payment will be sent to my mailing address unless I otherwise indicate. I have read, understand, and agree to the above Financial Policy and signed this form prior to any services being rendered.

Print Name/Signature _____ Date_____

Print Name/Signature Patient/Parent/Guardian

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HIPAA AUTHORIZATION FORM

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

Patient Name: _____ Date of Birth: _____

Notice of Privacy Practices: I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint.

*Patients aged 18 years and older: Please note that we cannot discuss your healthcare, insurance, or payment with your parents/others unless you fill out the appropriate information below.

Special requests to identify specific person(s) not authorized to receive my PHI, speak directly with the Practice Manager.
I may revoke my consent in writing by completing a new Acknowledgement of HIPAA Privacy Notice and Designation of Disclosure form except to the extent that the practice has already made disclosure in reliance upon my prior consent.

Communication/Messages: I understand that it may be necessary from time to time for Allergy & Asthma Specialists of Michigan to leave messages when we are unable to reach you. I wish to be contacted as follows: **(please designate preferred number to call)**

Communication/Message Prefercences		Yes	No
Home Telephone:	Leave message with confirmation of appointment, or call back only.	☐	☐
	Leave message with results, detailed information.	☐	☐
Cell Telephone:	Leave message with confirmation of appointment, or call back only.	☐	☐
	Leave message with results, detailed information.	☐	☐
	Send appointment reminders via text message.	☐	☐

Family Members/Parents/Friends: I authorize Allergy & Asthma Specialists of Michigan to share my Patient Health Information with the following:

Print Name: _____ Relationship: _____ Phone Number: _____

Print Name: _____ Relationship: _____ Phone Number: _____

*I have read, understand, and carefully completed the above HIPAA Authorization Form and signed this form prior to any services being rendered.

Print Name/Signature _____ Date_____
Print Name/Signature Patient/Parent/Guardian

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Medical History Form

What is your primary reason for your visit? _____

_____

Past Medical History (Circle any of the following that you currently have or have been treated for in the past):

ADD/ADHD	COPD	Liver Disease
Alcoholism	Depression	Lupus
Allergies (Environmental)	Diabetes	Migraines
Anemia	Diverticulitis	Nasal Polyps
Anxiety	Eczema	Osteoporosis
Arthritis	Eosinophilic Esophagitis (EoE)	Pneumonia
Asthma	Food Allergies	Prostate Disorder
Autism	GI problems	Psoriasis
Autoimmune Disease	GERDs/Reflux	Rashes
Bee Sting Allergy	Gout	Rheumatoid Arthritis
Bladder Problems	Heart Palpitations/ Irregular Rhythm	Seizures
Bipolar Disorder	Heart Disease	Sinus problems
Cancer (Type: _____)	Heart Murmur	Sleep Apnea
Celiac Disease	Hepatitis	Stroke
Cholesterol Problems	High Blood Pressure	Thyroid problems
Chronic Cough	Immune Deficiency	Ulcerative Colitis
Crohn's Disease	Irritable Bowel Syndrome	Uterine/Menstrual problems
Congestive Heart Failure	Kidney Disease	
	Kidney Stones	Other: _____

Past Surgical History (Circle any of the following surgeries that you have had performed in the past):

Adenoidectomy	Cataract surgery	Joint replacement:	
Appendectomy	C section	Shoulder (R or L)	Other:
Arthroscopic Joint Surgery	Deviated septum repair	Knee (R or L)	
Back Surgery	Ear tubes	Hip (R or L)	
Bariatric/Weight loss surgery	Hernia repair	Ovarian Surgery	
	Heart Bypass (CABG)	Pacemaker	
Bladder Suspension	Heart Stents	Prostate Surgery	
Breast (lumpectomy/mastectomy)	Hysterectomy	Sinus Surgery	
		Tonsillectomy	
Gallbladder Removal		Thyroid surgery	

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Family History (Please indicate any family history of the following):

	Grandparent	Mother	Father	Sibling	Children
Healthy and no problems					
Unknown					
Allergies					
Asthma					
Autoimmune problems					
Diabetes					
Eczema					
Food allergies					
Heart Disease					
Hives					
Hypertension (high blood pressure)					
Immune deficiency					
Thyroid disease					

Social History:

Smoking Status:	**Never smoked** **Former smoker**: quit date _____; daily average _____; # of years _____ **Current smoker**: daily average _____; # of years _____ **Second hand smoke exposure**: none parents spouse/partner care taker other: _____
Occupation:	
Hobbies:	
Housing:	**Location:** city suburban rural farm lake **I live in a**: house apartment/condo mobile/manufactured home **I have lived here for**: _____ (# months/years) **Age of home:** _____ (# months/years) **Foundation:** basement crawlspace slab **Air conditioning**: central none window unit **Heating**: natural gas forced air radiant heat wood stove **Air cleaners**: none free standing central furnace air cleaner **Bedroom**: wood floors wall to wall carpet area rug tile linoleum **Bed**: standard mattress waterbed feather pillow down comforter
Pets:	**Do you have pets?** Yes No **Are pets allowed in the bedrooms?** Yes No **If yes, how many of each type?** Dog(s)____ Age:____ Cat(s) ____ Age:____ Bird(s) ____ Age:____ Other:_____

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Review of Systems

General	Nose	Cardiovascular	Genitourinary	Neurologic
No problem Weight gain Fevers Chills Sweats Poor appetite Fatigue Weight loss	No problems Nasal congestion Loss of sense of smell Runny nose Post nasal drip Nose bleeds Itching Sneezing Sinus pain/pressure	No problems Chest pains Irregular heart beat/palpitations Shortness of breath when laying down flat	No problems Urinary Frequency Pain/burning with urination incontinence Difficulty emptying bladder Kidney stone Abnormal uterine bleeding Irregular menstrual cycle Prostate problems	No problems Headaches Weakness Numbness Dizziness Seizures tremors
Eyes	**Mouth/Throat**	**Respiratory**	**Musculoskeletal**	**Mental Health**
No problems Discharge Dry Eye pain Itchy Red Swollen Tearing Vision loss	No problems Hoarseness Difficulty swallowing Sore throat Lip swelling Throat clearing Itching of the roof of the mouth/throat Loss of sense of taste	No problems Cough Chest tightness Coughing blood Daytime sleepiness Shortness of breath Snoring Wheezing Difficulty with exercise	No problems Back pain Joint pain Joint swelling Leg swelling stiffness	No problems Addiction Anxiety/panic attacks Depression Hyperactivity Eating disorders Autism
Ears	**Blood/Lymph/Endocrine**	**Gastrointestinal**	**Skin**	**Allergic/Immune**
No problems Ear pain Ear pressure Hearing loss Fullness Itching Popping Infections Ringing Vertigo	No problems Swollen lymph nodes Blood clots Bleeding tendencies Blood transfusion Heat intolerance Cold intolerance Excessive thirst	No problems Recurrent bloating Heartburn Nausea Vomiting Diarrhea Abdominal pain Constipation Bloody stool Jaundice	No problems Eczema Hives Itching Swelling Rashes	No problems Recurring infections Environmental allergies Seasonal allergies Latex allergy Food allergy Drug reaction Bee sting allergy

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Medication Form

Current Medications and Supplements:

Medication Name	Milligrams	Times per day	Taking this for what diagnosis?

Allergies to medications

Name of medication	Reaction (hives, throat swelling, other)

☐ NO KNOWN DRUG ALLERGIES

Preferred Local Pharmacy	Mail Order Pharmacy
Name:	Name:
Street Address:	Street Address:
City:	City:
Telephone#:	Telephone#:
Fax#:	Fax#:

When was your last flu vaccine? _____

When was your last pneumonia vaccine? _____

When was your last Covid-19 vaccine? _____ Dose: _____ Manufacturer: J&J Moderna Pfizer

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Field of Clinical Allergy

The specialty of clinical allergy and immunology is complex and requires thorough attention to detail. It is the desire of this office to provide our patients with the most up to date and comprehensive allergy care available. We strive to deliver care to our patients in a friendly and personalized environment.

Your appointment is for: at a.m./p.m.

The initial allergy consultation requires approximately 2-2.5 hours. If you are unable to keep your appointment, please cancel your appointment at least 24 hours before. Failure to cancel a scheduled appointment will incur a $50 fee. During the initial consultation, a detailed history will be obtained, and an adequate physical exam will be performed. If indicated, allergy skin testing is typically performed at the initial consult. If necessary, pulmonary function testing and lab work may also be performed. To facilitate obtaining a complete and accurate history, please complete the enclosed questionnaire and bring it to the initial consultation. By sending you this allergy questionnaire for completion, we hope to provide you with ample time to give each question thoughtful consideration. It is also recommended that any pertinent outside medical records be obtained and brought to the consultation (including X-rays, CT scans, outside blood work, or allergy testing). At the initial consultation, the significant findings and test results will be summarized and an initial course of action will be recommended. On some occasions, the entire allergy evaluation may require several visits. When the entire allergy workup is completed, the doctor will summarize all the findings, test results, and discuss a treatment plan.

Fees and Insurance

Payment is expected when medical services are rendered. **Although we participate with several insurance plans, not all insurances cover allergy testing or treatment. We recommend that all patients contact their insurance and verify allergy testing coverage**.

IMPORTANT: If your insurance requires a referral, it is your responsibility to obtain the referral from your primary care physician. Without a referral we will have to reschedule your appointment. NOTE: Your primary care physician must authorize every visit to our office as well as any performed procedures.

DIVORCED PARENTS: Patients under the age of 18 years of age must be accompanied by an actual parent or legal guardian.

PATIENTS 18 YEARS OF AGE OR OLDER: Due to office policy and legislation (HIPAA law), patients must sign a release for the office to speak with a parent, spouse, or anyone other than the patient.

Skin Testing

Skin testing is essentially painless and can be performed at any age. If your child is to be tested, we will be happy to demonstrate the procedure to you. There are two types of skin tests which are helpful in determining the offending allergens: scratch tests and intradermal tests. Before applying scratch tests, the skin (usually the back) is cleansed with alcohol and allowed to dry. Different types of liquid diluted allergens are dropped on the back and then a special instrument is used to slightly scratch the skin. After 15 – 20 minutes, the allergen test drops are wiped off the surface of the skin and each test site is checked. The reaction of the skin is then noted to each allergen. A positive reaction consists of a raised, red, itchy welt that will clear up in less than 30 minutes. Scratch tests are usually performed first. The number of scratch tests may vary from only a few to over 50 (depending on the information that is required). Subsequently, if scratch test results need clarification or if no positive results occur, intradermal tests are performed. Intradermal tests are more sensitive tests that involve the injection of a small amount of allergen material into the skin. In 15 or 20 minutes, the allergen test is checked and the reactions are noted. The number of intradermal tests performed is usually less than 15.

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We ask our patients to refrain from taking antihistamine medications (allergy medications) for a period of 5 days prior to the initial visit since these medications interfere with skin testing results. If it is not possible to stop the medications because of the severity of your symptoms, please notify the office prior to your first visit. Oral steroids may be continued and do not interfere with allergy scratch or intradermal tests. If there are any questions, please call the office.

STOP THE FOLLOWING MEDICATIONS AT LEAST 5 DAYS PRIOR TO YOUR VISIT:

Alavert	Cetirizine	Desloratidine	Hydroxyzine	Vistaril
Allegra	Clarinex	Doxepin (antidepressant)	Levocetirizine	Zyrtec
Allegra D	Claritin	Elvail (antidepressant)	Loratadine	Zyrtec D
Atarax	Claritin D	Fexofenadine	Periactin	Xyzal

*IF YOU CANNOT STOP ALLERGY OR ANTIHISTAMINE MEDICATIONS, YOU MAY STILL BE SEEN FOR A CONSULTATION AND THE PROVIDER MAY PRESCRIBE ALTERNATIVE MEDICATIONS THAT DO NOT INTERFERE WITH SKIN TESTING. IF YOU ARE NOT CERTAIN AS TO WHAT MEDICATIONS NEED TO BE STOPPED, PLEASE CONTACT THE OFFICE FOR CLARIFICATION

DO NOT TAKE ANY OF THESE MEDICATIONS 2 DAYS PRIOR TO YOUR TESTING VISIT: (Please note that the list contains several allergy medications, cold/flu/sinus medications, sleep aids, stomach medications, anti-itch medications, anti-nausea preps, vertigo mediations, some allergy nasal sprays and eye drops).

Actifed	Aleve PM	Benadryl	Compazine	Dramamine	Nizatidine	Pedicare	Sinutab	Triaminic
Advil PM	Antivert (for vertigo)	Benylin	Contac	Drixoral	Nyquil	Pepcid (stomach aid)	Sominex	Tylenol PM
Alaway (eye drop)	Astelin (nasal spray)	Chlor-Trimenton	Coricidin	Dymista (nasal spray)	Patanase (nasal spray)	Phenergan	Tagamet (stomach aid)	Zaditor (Eye Drops)
Alka Seltzer	Astepro (nasal spray)	Chlopheniramine	Diphenhydramine	Famotidine (stomach aid)	Pataday (eye drops)	Promethazine	Tavist	Zantac (stomach aid)
Allerest	Axid (stomach aid)	Cimetadine (stomach aid)	Dimetapp	Meclizine (for vertigo)	Patanol (eye drops)	Ranitidine (stomach aid)	Theraflu	

YOU **DO NOT HAVE TO STOP** FLONASE (Fluticasone), NASACORT (Triamcinolone), RHINOCORT (Budesonide), OR TOPICAL STEROID NASAL SPRAYS FOR ALLERGY TESTING!
DO NOT STOP ANY: ASTHMA MEDICATIONS, ORAL STEROIDS, BLOOD PRESSURE MEDICATIONS, DIABETIC MEDICATIONS, CHOLESTEROL MEDICATIONS, HEART MEDICATIONS, PAIN MEDICATIONS, OR THYROID MEDICATIONS, ETC.

Patch Testing

Patch testing is also performed in this office. Patch testing helps confirm a diagnosis of contact dermatitis, which is a skin rash that occurs when certain substances come in contact with the skin. Patients who require patch testing will be scheduled for this type of testing, if needed, after an initial consultation/evaluation is completed. Patch testing is not affected by antihistamines but is affected by oral/injectable steroids and potent topical steroid creams/ointments.

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New Patient Insurance Information

What is the cost of a new patient appointment?
There is a range in each category of a new patient visit. The code is chosen based on the complexity and the number of problems the patient presents with. You will be charged for one new patient code.
New patient visit code/consultation code (99201-99205).

How many tests will be performed, and what is the cost of testing?
The number of tests performed is determined by your allergy symptoms, medical history, and examination performed by the provider. There are two types of tests: Percutaneous tests **(CPT Code 95004)** and Intradermal tests **(CPT Code 95024)** which are generally performed on the back. We also offer Patch tests which are used for evaluating skin rashes called "contact dermatitis" **(CPT Code 95044)**.

How much will the patient pay out-of-pocket?
This depends on your medical insurance benefits. Most insurance carriers have plans that cover allergy; However, with the continuous changes taking place in the insurance industry, we recommend that you contact your insurance carrier to verify your allergy benefit. Deductibles, co-pays, and co-insurance may apply.

- **Deductible**: the amount of money the patient pays before the insurance company begins to pay any amount as required by their specific plan they choose (gold, silver, bronze, etc.)
- **Co-Pay**: the amount the patient is required to pay per visit according to the insurance plan the patient has with the insurance carrier.
- **Co-insurance**: the amount the patient is required to pay according to a percentage (ex: visit is 80/20— insurance company pays 80% and patient pays 20%)

What should you do?
Call your health insurance company and ask them the allowable fee for the specific CPT test code (CPT stands for **C**urrent **P**rocedural **T**erminology) for the tests you are interested in (see below)! Again, it really does not matter what the fee is from the doctor's office. What matters is what amount the insurance company allows.

Allergy testing codes which may be performed:

- **Allergy skin test: code 95004**: This is the code for the "scratch test" now called prick or puncture test that is commonly used to check for environmental and food allergies. The number of tests performed is determined at the visit based on each individual's specific needs and discussion with the physician.
- **Allergy skin test: code 95024**: This is the code for the skin test where a small needle injection is performed under the skin. This is sometimes performed when the "scratch test" is negative but the history suggests an allergy. This step is generally NOT used for food testing.
- **Allergy patch testing: code 95044**: This is the code used for evaluating skin rashes called "contact dermatitis" such as nickel allergy or skin rashes from chemicals, dyes, rubber products, perfumes, make up etc. Patch testing kits typically come as a grouping with 36 tests, for example, rather than individually.
- **Penicillin skin testing: code 95018**: This testing requires a combination of "scratch" testing and intradermal (needle) testing with generally 11 tests performed. Typically, two preparations are used (PrePen® and Penicillin G).
- **Spirometry test: code 94010**: This is a breathing test that is done to check your lung flows and capacities. It is done to monitor asthma, COPD, and to monitor response to treatment.
- **Bronchospasm evaluation (pre and post bronchodilator spirometry)**: **code 94060**: This test is frequently done to evaluate a new patient with respiratory problems. It is also done to verify a response to an administered medication.

Allergen immunotherapy extract and injection codes for allergy injection treatment:

- **Allergy extract: 95165** (cost of the allergen serum to be injected which is specifically made for each patient).
- **One allergy injection: 95115**
- **Two or more allergy injections: 95117**