ALLERGY & ASTHMA ASSOCIATES

Patient's Name	M ____ F ____	Date of Birth
Address (street) (city) (state) (zip code)		
Home Telephone	Work Telephone	Cell Phone
Email Address	Social Security Number	
Marital Status		
Employer of Patient	Occupation	
Referred By	Primary Care Physician	

How did you first hear about us?	Friend	Physician	Website	Yellow Pages	Other	Explain:

Person Responsible for Account

Name	Relationship	
Address (street) (city) (state) (zip code)		
Home Telephone	Work Telephone	Cell Phone
Email Address	Social Security Number	
Employer	Occupation	

Office Policy Regarding Payment

Co-payments and deductibles are due at the time services are rendered. We will happily submitt all Insurance claims as a courtesy to our patients. For those insurance plans requiring referrals, it is YOUR RESPONSIBILITY TO OBTAIN THE REFERRAL or payment will be expected when services are rendered.

Primary Insurance	Subscriber
Policy/Membership Number	Group Number
Claim Address	Telephone Number
Secondary Insurance	Subscriber
Policy/Membership Number	Group Number
Claim Address	Telephone Number

I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to the undersigned physician for services rendered. A photocopy of the agreement shall be valid as the original.

Signature _____ Date _____

I recognize that I am responsible for charges incurred for services rendered and agree to pay those charges. (deductibles, co-payments and non-covered services)

Signature _____ Date _____

Allergy and Asthma Associates, P.A.
Patient Financial Agreement

Patient Name: _____ **DOB:** _____ **Date:** _____

Dear Patient,
Thank you for choosing Allergy and Asthma Associates, P.A. for your healthcare needs. We value our relationship with you and would like to tell you about the financial aspects of our services. Some of the information outlined within this policy includes our obligations to comply with insurance, Federal, Privacy and Fair Collections Acts. Your financial responsibilities related to your healthcare are included as well.

Red Flags Rule
The Federal Trade Commission developed a set of rules to protect consumers against identity theft. In order to protect your identity we may require a photo ID & Insurance Cards at each visit.

HIPAA
In compliance with HIPAA regulations, we are unable to discuss details of services rendered or to produce an itemized bill for any parties that are not the patient, unless authorized in writing by the patient.

Copayments, Deductibles & Co-Insurance Fees
Fees are based on the complexity of your visit or procedure. When you sign up for your insurance they will notify you of your out of pocket expenses such as a copayment, deductible or co-insurance. These terms are between you and your insurance and our office is not authorized to make any changes of any kind to these terms. Out-of-pocket expenses will be collected by our staff during your visit and are not contingent upon your receipt of a statement. We accept Visa, Master Card, Discover, and American Express, cash, personal checks and money orders. We accept secured payments over the phone at (410) 647-2600 or online through our patient portal (https://10921.portal.athenahealth.com/).

Form Completion & Medical Record Copying Fees
We do charge for the completion of school and/or camp medication forms. Attorney requests are subject to Maryland State Medical Records copying fees as outlined in our Records Fees Policy. Our office will notify you when documents are ready for pick up.

Late Arrival to Appointment
If you arrive to your appointment 15 minutes late, or later, we may need to reschedule your appointment.

Missed or Cancelled Appointments
As a courtesy to other patients who need to be seen, if you need to cancel your appointment please notify us at least 24 hours in advance. If we are not contacted 24 hours in advance to cancel an appointment, then a fee of $25.00 will be applied to No Show appointments for existing patients and $75.00 for new patients.

Returned Check Charge
Checks and credit card payments returned for non-Sufficient Funds (NSF) are subject to a $35.00 Fee (in addition to fees from your bank). Cash payments will be expected after more than one NSF fee.

Self- Pay Patients
Our practice will give you an estimate of what will be due. Sometimes it is medically necessary to add services after a care plan has been established. When this occurs, we will notify you of these costs. Payment for all

services is due at your visit. In the event you have insurance but do not provide us with the proper referral or authorization from a PCP or insurance, the patient will be responsible for payment.

Payment Plans

In some instances, our office will work with you to develop a plan to assist you in paying outstanding balances with our practice. Our billing department can be reached at (410) 647-2600 or through our patient portal.

Coordination of Benefits

Sometimes you may have more than one insurance company paying for your medical expenses. In order to have the correct insurance pay on your behalf, you must notify us of the correct sequence of primary, secondary and/or tertiary. Failure to do so could result in all insurances denying your medical claims. If you do not provide us with accurate insurance and coordination of benefits information in a timely fashion you may become responsible for the full charges due.

Non-Payment of Outstanding Accounts

We make many efforts to assist our patients with managing their medical bills. Please contact us if you are having difficulty with payments. Accounts that are not paid in a reasonable amount of time will be sent to an external collection agency. Should the account be referred to a collection agency or an attorney for past due amounts, the guarantor may incur attorney's fees, court costs and all applicable collections expenses.

Referrals

Some insurance carriers require that you obtain a written referral from your primary care physician for our specialty services. Patients are responsible for obtaining referrals from their Primary Care Physician (PCP) and bringing them to the visit with us. If you have forgotten your referral, we require completion of our "No Referral Waiver" agreement in order to be treated. We will only perform services and file claims to your insurance for authorized services approved by your insurance carrier's guidelines. Payment for services that have not been approved by a PCP are considered self-pay and payable at the time of service.

Assignment of Insurance Benefits and Third Party Claims

By signing this document you authorize benefits from your insurance company to be made on your behalf to Allergy and Asthma Associates, P.A. for services furnished to you by our providers. You also authorize release of your medical information necessary to process your insurance claims. If you do not agree with this then our office will be unable to submit insurance claims on your behalf and payment in full will be expected from the patient prior to services being provided.

Financial Attestation

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the financial balance of any services provided to me. I also understand that it is my responsibility to know what the terms of my insurance are and to be in compliance with those terms. Payment is due at the time services are rendered which includes co-payments, deductibles, and co-insurance with my carrier.

I have read both pages of this document and agree to the terms outlined. I will notify the office of any changes in my personal address, contact, and/or billing information.

Name of Patient: _____

Signature of Patient: _____ Date: _____

Allergy and Asthma Associates, P.A.
James Banks, M.D. & Timothy Andrews, M.D.

Permission to Leave Messages

I, _____, (patient/parent) hereby grant permission to Allergy and Asthma Associates, P.A. to:

- ☐ Leave detailed messages on my voicemail that may contain my personal health information.
- ☐ Leave detailed messages with another member of my household/family that may contain my personal health information.

I understand that I will need to provide a written request to Allergy and Asthma Associates, P.A. if I choose to relinquish this permission.

Form completed for:

[ ] Patient_____

_____ _____

Signature Date

277 Peninsula Farm Road, Arnold, MD 21012
(o) 410-647-2600 (w) www.annapollendocs.com (f) 410-647-4953

PATIENT NAME: _____

DATE OF BIRTH: _____

OCCUPATION: _____

CURRENT DATE: _____

ALLERGY & ASTHMA ASSOCIATES

JAMES R. BANKS, M.D.
TIMOTHY ANDREWS, M.D.
277 PENINSULA FARM ROAD
ARNOLD, MD 21012
410-647-2600

1 Name of person filling out this form and relation to the patient:_____

2 Who suggested you visit us?_____

3 Who is your primary physician?_____

4 Is there any other provider who should receive a copy of our report?_____

5 What is the reason you were referred to us today? (asthma, hay fever, food, bee, medication allergy, etc)

_____

_____

6 What specific problems or symptoms are you having?(sneezing, cough, etc.)_____

_____

Please answer YES or NO if you have had any of the following within the past year or more:

NOSE

no problems Y ___ N ___
itch Y ___ N ___
clear drainage Y ___ N ___
discolored mucus Y ___ N ___
sneezing Y ___ N ___
post-nasal drip Y ___ N ___
nose rubbing Y ___ N ___
nosebleeds Y ___ N ___
polyps Y ___ N ___
poor sense of smell or taste Y ___ N ___
blockage Y ___ N ___

SINUSES

no problems Y ___ N ___
fullness/pressure/pain Y ___ N ___
recurrent sinusitis Y ___ N ___
recurrent head colds Y ___ N ___

CHEST

no problems Y ___ N ___
coughing Y ___ N ___
wheezing Y ___ N ___
tightness/pressure Y ___ N ___
short of breath Y ___ N ___
bronchitis Y ___ N ___
pneumonia Y ___ N ___
coughed up blood Y ___ N ___
coughed up sputum Y ___ N ___
trouble keeping up with peers when exercising Y ___ N ___
wake up coughing/wheezing Y ___ N ___
coughs with exercise Y ___ N ___
ER visit for asthma attacks Y ___ N ___
hospitalizations for asthma/pneumonia Y ___ N ___

EYES

no problems Y ___ N ___
tearing Y ___ N ___
itching Y ___ N ___
discharge Y ___ N ___
redness Y ___ N ___
dryness Y ___ N ___
vision changes Y ___ N ___
blurred vision Y ___ N ___
glaucoma Y ___ N ___
wear soft contacts? Y ___ N ___

EARS

no problems Y ___ N ___
itch Y ___ N ___
pop Y ___ N ___
plugging Y ___ N ___
infections Y ___ N ___
poor hearing Y ___ N ___
ringing Y ___ N ___

Gastrointestinal

no problems Y ___ N ___
heartburn Y ___ N ___
reflux Y ___ N ___
vomiting Y ___ N ___
diarrhea Y ___ N ___
swallowing difficulties Y ___ N ___
stomach pain Y ___ N ___
food intolerance Y ___ N ___
hepatitis Y ___ N ___
bloating Y ___ N ___

THROAT & MOUTH

no problems Y ___ N ___
itching Y ___ N ___
recurrent sore throats Y ___ N ___
hoarseness Y ___ N ___
throat clearing Y ___ N ___
bad breath Y ___ N ___
canker sores Y ___ N ___

SKIN

no problems Y ___ N ___
rash Y ___ N ___
hives/welts Y ___ N ___
swelling Y ___ N ___
itching Y ___ N ___
eczema Y ___ N ___
dryness Y ___ N ___

CONSTITUTIONAL

no problems Y ___ N ___
headaches Y ___ N ___
irritability Y ___ N ___
aggressive behavior Y ___ N ___
poor sleeping Y ___ N ___
fatigue Y ___ N ___
snoring Y ___ N ___
cold/heat intolerance Y ___ N ___
dizziness Y ___ N ___
fever Y ___ N ___
weight changes Y ___ N ___
night sweats Y ___ N ___
growth delay Y ___ N ___
altered school/work performance Y ___ N ___
loss of balance Y ___ N ___
dizziness on change of positions Y ___ N ___

Which of the above are of greatest concern to you and impact most on your quality of life?_____

_____

_____

PATIENT NAME: _____

7 Please provide us with some details of the history of your problem.
When did it begin? Was it preceded by some other type of allergic condition? Has there been a trend or variation of symptoms or severity over the years?_____ _____

_____
_____
_____

8 Have you noticed a pattern with your symptoms? Is it worse in certain locations, months or seasons?

_____
_____
_____

Are your symptoms affected by:

dust Y ___ N ___	cut grass Y ___ N ___	stress Y ___ N ___
cats Y ___ N ___	mold/mildew Y ___ N ___	spring Y ___ N ___
dogs Y ___ N ___	wind Y ___ N ___	summer Y ___ N ___
other animals Y ___ N ___	weather changes Y ___ N ___	fall Y ___ N ___
leaf raking Y ___ N ___	fumes/chemical odors Y ___ N ___	winter Y ___ N ___
feathers Y ___ N ___	poor air quality Y ___ N ___	respiratory infections Y ___ N ___
soaps/detergents Y ___ N ___	viruses Y ___ N ___	
exercise Y ___ N ___	laughter Y ___ N ___	
heat/cold Y ___ N ___	newsprint Y ___ N ___	

(See Question #15 for foods, bee stings, latex)

9 What has provided the most relief (avoidance, specific medicines, allergy shots...)?

_____
_____
_____

10 What hasn't helped?_____

_____
_____

11 If you have undergone prior allergy evaluation, please list physician, approximate date, and any known details regarding test results and treatment._____

_____

Have you had a chest x-ray or sinus CAT scan within the past 3 years? Y___N___ If so, where?_____

_____

12 Describe your smoking history:

never _____ Average number of packs/day over the years_____
former Y ___ N ___ Numbers of years you have smoked_____
current Y ___ N ___ If applicable, how many years ago did you stop?_____

13 Please list all current medications, both prescription and over the counter. Also list all herbal and/or nutritional products: When were meds started?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

14 Please list all known medication allergies and intolerances. Describe the nature of reaction or side effect for each drug and approximate date or age at which the problem surfaced._____

_____
_____
_____

PATIENT NAME: _____

15 Please list all known or suspected allergies or intolerances to foods, food additives and colorants, stinging insect venom, and latex (natural rubber) products. Describe the nature of the reaction and approximate date or age at which the problem surfaced.

_____

_____

_____

16 Have you had contact allergies to poison ivy, adhesives, metals, cosmetics, etc.? Describe:

_____

_____

17 If not yet covered above, have you had any of the following:

asthma Y ___ N ___	recurrent sinusitis Y ___ N ___	sinus surgery Y ___ N ___
nasal allergies Y ___ N ___	recurrent ear infections Y ___ N ___	pneumonia Y ___ N ___
eczema Y ___ N ___	PE ear tubes Y ___ N ___	recurrent bronchitis Y ___ N ___
recurrent hives Y ___ N ___	adenoidectomy Y ___ N ___	meningitis Y ___ N ___
recurrent swelling Y ___ N ___	tonsillectomy Y ___ N ___	abscesses Y ___ N ___

18 Please describe your routine for regular exercise:_____

_____

Do you exercise regularly outdoors within 500 yards of a major roadway? Y___N___

19 **Home Environment:** Age of home_____ rent_____ own_____

Number of indoor cats? _____ For how long?_____
Number of indoor dogs? _____ For how long?_____
Other furred pets in home?_____ For how long?_____
If cats or dogs were present only in past, how long has it been since such pets were in the home?
_____ What type of animal?_____

Number of occupants who ever smoke in the home?_____
Relationship of smoker(s) to patient?_____

Central AC? Y___ N___
If you have central AC do you routinely open windows seasonally, temperature permitting? Y ___ N ___

Your bedroom:
wall to wall carpet Y ___ N ___ hardwood or tile Y ___ N ___ area rugs Y ___ N ___
washable throw rugs Y ___ N ___ (not washable)
Are pillows covered in special allergen-proofed encasings? Y ___ N ___
Is top mattress similarly encased? Y____ N____ (N/A if waterbed)
is box spring encased? Y___ N___ Is comforter encased? Y ___ N ___

Is patient in a daycare setting? Y___ N___ If so, how many other children in attendance?_____
Pets at daycare?_____ Smokers? Y ___ N ___
Other exposure to pets outside the home? (Friends, neighbors, relatives)_____

_____

If you live much of the year in a college dorm or apartment, please comment on that setting with the above issues in mind:_____

_____

_____

Are there any particular concerns regarding either the home or work setting not addressed above? (e.g., mouse or cockroach infestations, water damage, mold growth, leaky roof, poor ventilation, etc.)
Please elaborate:_____

_____

PATIENT NAME: _____

20 **Review of Systems** (Have you had any of the following within the past year?)

Heart

no problems	Y ___	N ___
high blood pressure	Y ___	N ___
irregular beats	Y ___	N ___
murmur	Y ___	N ___
heart attack	Y ___	N ___
surgery	Y ___	N ___
ankle swelling	Y ___	N ___
angina/chest pain	Y ___	N ___
shortness of breath:		
when walking	Y ___	N ___
when lying down	Y ___	N ___
when climbing 1 flight of stairs	Y ___	N ___
on walking several blocks	Y ___	N ___

Endocrine

no problems	Y ___	N ___
diabetes	Y ___	N ___
thyroid problems	Y ___	N ___
brittle nails	Y ___	N ___
change in hair texture	Y ___	N ___
change in skin texture	Y ___	N ___
premature puberty	Y ___	N ___
delayed puberty	Y ___	N ___

Musculoskeletal

no problems	Y ___	N ___
arthritis	Y ___	N ___
fibromyalgia	Y ___	N ___
osteoporosis	Y ___	N ___
backaches	Y ___	N ___
muscle spasms	Y ___	N ___
joint redness	Y ___	N ___
joint swelling	Y ___	N ___
joint heat	Y ___	N ___

Blood/Lymphatic

no problems	Y ___	N ___
anemia	Y ___	N ___
easy bruising	Y ___	N ___
easy bleeding	Y ___	N ___
swollen glands	Y ___	N ___
blood clots	Y ___	N ___
tired without reason	Y ___	N ___

Genitourinary

no problems	Y ___	N ___
bedwetting	Y ___	N ___
frequent urination	Y ___	N ___
difficult urination	Y ___	N ___
yeast infection on antibiotics	Y ___	N ___
accidental urination with cough	Y ___	N ___

Neuropsychiatric

no problems	Y ___	N ___
migraine	Y ___	N ___
seizures	Y ___	N ___
unconscious spells	Y ___	N ___
tingling/weakness in hands/feet	Y ___	N ___
trembling of extremity	Y ___	N ___
difficulty concentrating	Y ___	N ___
impulsive behavior	Y ___	N ___
chronic anxiety	Y ___	N ___
memory difficulty	Y ___	N ___
stress	Y ___	N ___
depression	Y ___	N ___
irritability	Y ___	N ___
mood swings	Y ___	N ___
difficulty interacting	Y ___	N ___
drug/alcohol problems	Y ___	N ___

Lungs

pneumonia	Y ___	N ___
pleurisy	Y ___	N ___
collapsed lung	Y ___	N ___
bronchitis	Y ___	N ___
last TB test		
Pos_____ Neg ___		

Liver

hepatitis	Y ___	N ___
cirrhosis	Y ___	N ___

Other symptoms not listed above? _____

_____

_____

_____

21 **Past Medical History - Have you had any of the following at any time in the past?:**

Tuberculosis	Y ___	N ___
Positive TB test	Y ___	N ___
Migraine	Y ___	N ___
Diabetes	Y ___	N ___
Cataracts	Y ___	N ___
Glaucoma	Y ___	N ___
GERD	Y ___	N ___
stroke	Y ___	N ___
abnormal bone density	Y ___	N ___
thyroid disease	Y ___	N ___

(Graves, Hashimotos, thyroiditis, tumor, hyperthyroidism, hypothyroidism)

Hiatal Hernia	Y ___	N ___
Ulcers	Y ___	N ___
Irritable Bowel	Y ___	N ___
Crohn's Disease	Y ___	N ___
lactose intolerance	Y ___	N ___
hepatitis	Y ___	N ___
arthritis	Y ___	N ___
cancer	Y ___	N ___
osteoporosis	Y ___	N ___
ADD/ADHD	Y ___	N ___

epilepsy/seizures	Y ___	N ___
congenital defects	Y ___	N ___
congenital heart disease	Y ___	N ___
heart attack	Y ___	N ___
angioplasty	Y ___	N ___
bypass surgery	Y ___	N ___
abnormal stress test	Y ___	N ___
drug addiction	Y ___	N ___
alcoholism	Y ___	N ___

PATIENT NAME: _____

For Children Specifically

Birth complications Y ___ N ___ ADD Y ___ N ___ learning disability Y ___ N ___
Feeding problems Y ___ N ___ ADHD Y ___ N ___ growth delay Y ___ N ___
Adverse reactions developmental delay Y ___ N ___
to vaccines Y ___ N ___

Other medical problems not listed above:_____

_____

List any surgeries with approximate dates:_____

_____

22 **Family History**

	Good Health	Asthma	Hayfever	Eczema	Food Allergies	Other Diseases
Mother	Y ___ N ___	Y__N__	Y__N__	Y ___ N ___	Y__N__	Y ___ N ___
Father	Y ___ N ___	Y__N__	Y__N__	Y ___ N ___	Y__N__	Y ___ N ___
Siblings (any)	Y ___ N ___	Y__N__	Y__N__	Y ___ N ___	Y__N__	Y ___ N ___
Offspring	Y ___ N ___	Y__N__	Y__N__	Y ___ N ___	Y__N__	Y ___ N ___

Family history of cystic fibrosis? Y ___ N___ Family history of glaucoma? Y ___ N ___
Family history of immune deficiency? Y___ N___ Family history of thryroid disease? Y ___ N ___

23 **Immunization History:**

Have you had chicken pox? Y___ N___ Or did you get vaccinated for it? Y___ N___
Are other childhood immunizations up to date? Y ___ N ___
Do you routinely receive a flu shot each fall? Y ___ N ___
When was your last TB skin Test?_____ Unknown_____

24 **Social History**

Marital Status M ___ S ___ D ___ W___ N/A
Hobbies:_____
If in college, where and what primary field of study?_____
Your estimated alcohol consumption?_____
Who lives in your home?_____
If you are a minor: Are parents married and living together? Y ___ N ____
If not, are parents separated, divorced, or is a parent deceased?_____
Do you divide time between homes?_____
Explain _____
Does only one parent have legal custody? Y ___ N ___
Explain _____

Any further comments?_____

_____

_____ _____
Signature of person completing form Date

M.D. REVIEW: _____

SPECIAL INSTRUCTIONS

All antihistamines and certain cough suppressants and antidepressants must be stopped for designated periods of time before testing. See "Medications to be Stopped" on our website. Check with the office if you have any doubt whether you may continue to take any given medication. Patients evaluated for HIVES and swelling should NOT discontinue medication. Please wear short sleeves. Please bring copies of any chest or sinus x-rays & CT scans with you. Office space is limited, please do not bring others with you. Please do not mail forms, just bring them with you. Thank you