Canton Asthma & Allergy
Pediatric & Adult Care

PATIENT INFORMATION / INSURANCE / FINANCIAL POLICY FORM
Please READ carefully and complete Form - **(√)** Sign/Initial where indicated

Date: _____ Chart # _____

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PATIENT INFORMATION

Patient Name (Last) _____ First: _____ M: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Billing Address (If Different): _____

Home: (____) _____ Cell: (____) _____ Work: (____) _____ Birth Date: _____

SS#: _____ Sex: [ ]M [ ]F Marital Status: [ ]S [ ]M [ ]W [ ]D Specialist Co-Pay Amount $_____

Email Address: _____ Employer: _____

Spouse/Partner Name: _____ Phone: _____ Other Emergency Contact: _____ Phone: _____

IF PATIENT IS A MINOR – PARENT/GUARDIAN MUST BE PRESENT FOR MINOR TO RECEIVE TREATMENT

Father's Name: _____ Employer: _____ SS# _____ WorkPhone: _____

Mother's Name: _____ Employer: _____ SS# _____ WorkPhone: _____

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WE DO NOT ACCEPT MEDICAID HEALTH INSURANCE OF ANY TYPE

_____ **(√)** Initial: **INSURANCE INFORMATION** I give permission to bill my insurance company and assign payment to Canton Asthma & Allergy, P.C.

Primary Insurance: _____ Effective Date: _____ Policyholder Name: _____ Birth date: _____

Secondary Insurance: _____ Effective Date: _____ Policyholder Name: _____ Birth date: _____

Tertiary Insurance: _____ Effective Date: _____ Policyholder Name: _____ Birth date: _____

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_____ (√) Initial: **RELEASE OF HEALTH INFORMATION**

I CONSENT TO MESSAGES RELATING TO MY HEALTH CARE TO BE LEFT ON MY PHONE NUMBER(S) ON FILE, INCLUDING X-RAY/LAB RESULTS.

By law, except for the parent/guardian of a minor and other physicians directly involved in their medical care, we are unable to share patient health information. Please check if you would:

[ ] LIKE SOMEONE ELSE WITH YOU DURING YOUR APPOINTMENT [ ] CONSENT TO OUR DISCUSSING YOUR MEDICAL INFORMATION WITH ANOTHER PERSON

Please list the Name and Relationship of person(s) to whom you give consent. - Consent may be revoked by submitting written notification to our Canton office.

I give permission for Canton AA to share my protected health information with: Name_____Relationship_____

Name_____Relationship_____ Name_____Relationship_____

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_____ (√) Initial: **PATIENT CONSENT TO ALLERGY SKIN TESTING** I understand and agree that should it be necessary, a Canton Asthma/Allergy medical professional will perform standard Greer Prick Testing (and intradermal [injection] test(s) if deemed medically necessary), to test me for allergic reaction(s). I agree these tests are being ordered based on the oral history of symptoms I provide today, and my doctor's professional medical opinion which may also be based on medical data provided by previous clinic notes or laboratory results contained in my medical record. I agree to allergy skin testing being performed should it be necessary. As stated in the Policy below, I understand my insurance carrier will be billed for allergy skin testing but **I am ultimately responsible for any charges incurred for allergy skin testing and any other services provided by Canton Asthma & Allergy.**

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FINANCIAL POLICY

It is YOUR responsibility to check that our services are covered under your insurance plan - Confirm allergy testing (CPT4: 95004 /95024) and office visit (CPT4: 99214 and 99215) is covered by your insurance. Should you anticipate allergy shots confirm coverage (CPT CODES: 95115 / 95117 / 95165). Canton Asthma/Allergy accepts cash, check, Master Card, Visa, and Discover credit cards. Please carefully read and then sign below, to confirm you understand and agree to these terms as listed.

OUR relationship is with YOU, NOT your medical insurance company. Canton Asthma/Allergy will bill your medical insurance but your health insurance policy is a contract between you, your employer, and your insurance carrier. All charges for medical services we provide to you are ultimately YOUR responsibility.

Co-pay and any unpaid past due balance is due at time of service. If copay is not paid at time of service, a billing fee will be added to your charges. Billed balances are due in full within 30 days. No further services will be provided until your account is paid in full unless other arrangements have been made with the Manager.

Canton Asthma/Allergy will bill the insurance carrier information we have as last provided by you. Should we not receive payment as a result of your failure to notify us of any change in insurance coverage, we may ask you to pay your charges in full. Additionally, should you fail to provide information requested by your insurance company (i.e. Coordination of Benefits [COB], etc.), we can require charges to be paid in full more than 60 days overdue. In both circumstances, a detailed receipt will be provided so that you may submit the receipt to your insurance company for direct reimbursement.

Returned checks will incur an additional insufficient funds charge to patient account, and result in our refusal to accept personal checks from you in the future.

Established patients who miss their scheduled appointment will be responsible for a "NO SHOW" fee. We require 24-hr notice of cancellation in advance of your scheduled appointment. After hours calls are accepted; dial 734/394-2661 and choose option 1 to leave a message, or send us an email using our website.

Thirty (30) days following our 2nd mailed statement, unpaid balance due will be submitted to our Collection Company (IC Systems) and is subject to a Collection Fee. Collection agency fees are based on a percentage at a maximum of 33% of the debt and all costs and expenses, including reasonable attorney fees Canton Asthma/Allergy may incur in collection efforts, as allowed by Law.

We understand that temporary financial problems may affect timely payment of your balance. Please communicate any problem to us our Canton office (734/394-2661) so we can assist you in the management of your account. I understand and agree to the Financial Policy terms listed above. I received a copy of this Financial Policy for my records.

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(√) Patient Signature Print Name Relationship to Patient

(Parent/Guardian if Patient is a Minor)

Witness - Canton Asthma & Allergy, PC Today's Date

The CPT4 Codes listed in the **NEW PATIENT** column are those most likely to be billed the first time you are seen in our Clinic. Before your first appointment (or prior to returning for a revisit or any type of testing), please check with your insurance company to make sure the visit/test(s) is covered.

REMEMBER, the patient (or parent/guardian if patient is a minor) is ultimately responsible for any fees incurred. Canton Asthma & Allergy PC, is not responsible for billed services not covered by patient's insurance carrier.

		REVISIT	NEW PATIENT
OFFICE VISIT WITH PHYSICIAN			
LEVEL 2	10 MINS	99212	
LEVEL 3	15 MINS	99213	
LEVEL 4	25 MINS	99214	99204
LEVEL 5	40 MINS	99215	99205
PROLONGED CARE	+ 61 MINS	99354	
#_____	ADDT'L 15MINS	99355	
ASTHMA / BREATHING PROBLEM			
INHALER DEMONSTRATION		94664	94664
OXIMETRY		94760	
SPIROMETRY / PEAK FLOW		94010	94010
BRONCHOSPASM EVALUATION		94060	
INHALATION BRONCHIAL CHALLENGE		95070	95070
GAS DILUTION		94727	94727
DETERMINATION OF DIFFUSION CAPACITY		94729	94729
ALLERGY TESTING			
PUNCTURE/PRICK		95004	95004
INTRADERMAL		95024	
ALLERGY SHOT CODE			
ALLERGY INJECTION	1 SHOT	95115	
ALLERGY INJECTION	2 SHOT	95117	
ALLERGEN PREP	(SERUM FOR SHOTS)	95165	
OTHER TESTING			
DRUGS / BIOLOGICS		95018	
RAPID DESENSITIZATION		95180	
PATCH		95044	
VENOM (STINGING INSECTS)		95017	
INGESTION CHALLENGE		95076	
OTHER ALLERGY SHOT			
VENOM (STINGING INSECTS)	1 STING	95154	
	2 STING	95146	
	3 STING	95147	
	4 STING	95148	
	5 STING	95149	
VENOM PREP (SERUM FOR VENOM SHOT)		95165	
SPECIALTY (BIOLOGIC) ASTHMA SHOT			
XOLAIR	J CODE 2357	96401	
NUCALA	J CODE 2182	96372	

Canton Asthma & Allergy
Pediatric & Adult Care

Steven V. Stryk, MD
Emily T. Wang, MD

Date of Appointment: Day: Time:

Antihistamines and drugs that may affect testing:	**LENGTH OF TIME TO BE OFF**
All regular antihistamines such as Benadryl, Chlorpheniramine, Antihistamine and Decongestant combinations, OTC cold and cough preparations, and sleep aids such as Tylenol PM, etc.	48 hours
Allegra, Allegra D (generic: Fexofenadine), Astelin Nose Spray, Optivar Eye Drops (Azelastine), Emadine Eye drops, Astepro, Dymista, Zyrtec, Zyrtec D (generic: Cetirizine), Zantac (generic: Ranitidine), Allertec, Atarax (generic: Hydroxyzine), Vistaril, Periactin, Axi (Nizatidine), Tagamet (Cimetadine), Xyzal (Levoceterizine)	5 days
Claritin, Claritin D, (generic: Loratadine) Alavert, Clarinex, Clarinex D, Patanase / Pataday / Patenol / and/or Pazeo Eye Drops	7 days

FOR EXAMPLE
If your appointment is on a Thursday and the length of time to discontinue your medication is 4 days, take your last dose on the Saturday before your appointment.

If you are taking medication for RASH, SWELLING, or HIVES – Do Not Stop! *

* There are medications that affect skin results, including medicines used to treat ulcers and heartburn (e.g. Zantac) and antidepressants (e.g. Elavil) which may be used to treat headaches – DO NOT stop taking these medications! As a rule, asthma medications do not affect skin test results and may be continued as prescribed. Please call our office if you have any questions.

CANTON OFFICE – TEL: 734-394-2661
1600 S Canton Center, #360
Canton, MI 48188

www.CantonAllergy.com
Fax: 734-394-2666

NOVI OFFICE – TEL: 248-474-9661
39475 Lewis Drive, #140
Novi, MI 48377

Canton Asthma & Allergy
Pediatric & Adult Care

Steven V. Stryk, MD | Emily T. Wang MD

Patient Name: _____ Date of Birth: _____ Patient PCP/Referring Dr: _____

What Pharmacy do you Use? _____ Street/City/Phone_____

HISTORY: What brings you to our Clinic? _____ When do symptoms occur? [ ] Spring [ ] Summer [ ] Fall [ ] Winter

How long have you had the problem(s)? _____ Symptoms are [ ] Better [ ] Worse Symptoms interfere with [ ] Sleep [ ] School [ ] Work

If you have nasal or asthma problems, please check all items that your symptoms are aggravated by:

[ ] Dust [ ] Cats [ ] Dogs [ ] Basements [ ] Spring Pollens [ ] Fall Pollens [ ] Cut Grass

[ ] Dead Leaves [ ] Infections [ ] Exercise [ ] Smoke [ ] Perfume [ ] Aspirin Other:

WORK ENVIRONMENT: Job title? _____Are you exposed to: [ ] Solder [ ] Industrial Solvents [ ] Metal Fumes [ ] Other_____

HOBBIES: What do you do in your spare time? _____ LATEX ALLERGY: [ ] NOT APPLICABLE [ ] YES

HIVES: [ ] NOT APPLICABLE How long have you had the present problem? _____ Have you had hives in the past? _____

Are there any specific triggers that you recognize that bring on your hives? _____

ECZEMA: [ ] NOT APPLICABLE How long have you had the problem? _____ Aggravating factors? _____

FOOD SENSITIVITIES: [ ] NOT APPLICABLE [ ] YES If yes, check all that apply below about what symptoms occur after what FOODS?

SYMPTOM	SOY	PEANUTS	TREE NUTS	EGG	WHEAT	FISH	SHELL FISH	OTHER
SKIN (RASH)								
BREATHING								
STOMACH UPSET								

DRUG ALLERGIES: [ ] NOT APPLICABLE Name of drug(s)? _____ Reaction(s): _____

INSECT STING ALLERGY: [ ] NOT APPLICABLE [ ] YES If yes, type of reaction & when: _____

TREATMENT: Current allergy/asthma medication(s): _____

Previous allergy/asthma medications: _____

PREVIOUS ALLERGY TESTING OR EVALUATION: [ ] NO [ ] YES If yes, when? _____ Where? _____ Results: _____

ALLERGY IMMUNOTHERAPY: Have you ever had allergy shots? [ ] NO [ ] YES If yes, for how long? _____ Helpful? [ ] YES [ ] NO

NASAL/SINUS SYMPTOMS: [ ] Runny Nose [ ] Stuffy Nose [ ] Itchy Nose [ ] Itchy Eyes

[ ] Itchy Throat [ ] Sneezing [ ] Sinus Pressure [ ] Sinus Infections

ASTHMA: Number of days wheezing? _____/Week Waking from sleep? _____/week Does exercise trigger asthma? [ ] YES [ ] NO

Have you needed to go to an ER for your asthma in the past 12mos? [ ] YES [ ] NO Smokers in home: [ ] YES [ ] NO

Have you been Hospitalized for your asthma in the past [ ] NO [ ] YES Number of times? _____

Taken oral steroids in past 12mos for asthma? [ ] NO [ ] YES When was your last chest x-ray? _____ Where was it done? _____

ENVIRONMENTAL: Do you work outside your home? [ ] NO [ ] YES If yes, describe your job: _____

Have you ever lived outside the Midwest? [ ] NO [ ] YES If yes, where and when? _____

Have you traveled outside the Continental United States? [ ] NO [ ] YES If yes, where and when? _____

ENVIRONMENT – HOME: Heating [ ] Gas [ ] Electric [ ] Other _____ Cooling: [ ] Central Air [ ] Window [ ] None

Do you have a basement? [ ] YES [ ] NO Crawl Space? [ ] YES [ ] NO Mold Issues? [ ] YES [ ] NO

Bedding – Pillow [ ] Feather [ ] Synthetic Bedroom Floor? [ ] Carpet [ ] Wood [ ] Tile/Vinyl Pets? [ ] Cat [ ] Dog [ ] Other_____

PERSONAL HISTORY: Do you smoke? [ ] NO [ ] YES Have you ever smoked? [ ] NO [ ] YES If yes, when: _____

Do you use recreational drugs? [ ] NO [ ] YES If yes, what type? _____

Do you drink alcohol? [ ] NO [ ] YES If yes, how often and how much? _____

FAMILY HISTORY: - Check all that apply below.

RELATIVE	NASAL ALLERGY	ASTHMA	ECZEMA	HIVES (RASH)	ANGIOEDEMA
FATHER					
MOTHER					
SIBLINGS					
CHILDREN					