Canton Asthma & Allergy
Pediatric & Adult Care

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

Date: _____ Chart # _____

**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: _____

**WE DO NOT ACCEPT MEDICAID HEALTH INSURANCE OF ANY TYPE** **WE DO NOT ACCEPT MEDICAID HEALTH INSURANCE OF ANY TYPE**

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

_____ (√) 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_____

_____ (√) Initial: **PATIENT CONSENT TO ALLERGY TESTING** I agree to allergy skin testing being performed should it be necessary and I acknowledge that I am ultimately responsible for any charges for service provided by Canton Asthma & Allergy. I understand test(s) will be ordered based on the oral history of symptoms I provide today, and/or my doctor's professional medical opinion. This opinion may also be based on medical data provided in previous clinic notes or laboratory results contained in my medical record. As stated in the Financial Policy below, I understand my insurance carrier will be billed for allergy skin testing but I am ultimately responsible for all charges.

**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) are covered services. These codes are also available on our website, www.CantonAllergy.com (PATIENT INFORMATION; Forms for Your Visit; New Patient Packet; page 3). Should you anticipate allergy shots confirm CPT CODES: 95115 / 95117 / 95165 are covered services.

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 your copay is not paid at time of service, a billing fee is added to the charges. **Patient billed balances are due in full within 30 days**. No further services will be provided until the account is paid in full unless other arrangements have been made with the Manager. Canton Asthma/Allergy accepts Cash, Check, Money Order, Master Card, Visa, American Express, and Discover credit cards. We offer CareCredit, a zero interest credit card if paid in full according to same as cash time Terms, should you be interested in a payment plan. Ask receptionist for details.

An unpaid balance more than sixty (60) days overdue may be submitted to our Collection Company (IC Systems) and is subject to a Collection Fee. The Collection Fee is based on a maximum percentage of the debt as allowed by law and is assessed to the Practice for every account submitted to IC Systems. The Fee is passed on to the patient balance due when submitted to IC Systems. Once an account is submitted to IC Systems (800/685-0595), patient payment(s) are collected by them until the account is cleared. Accounts in Collections ARE reported to credit reporting agencies. A patient with an account in Collections will not be scheduled until the debt is cleared and could result in dismissal from the Practice.

Canton Asthma/Allergy will bill the insurance carrier information we have as last provided by you. You may be asked to pay your charges in full should: (1) we not receive payment as a result of your failure to notify us of a change in coverage, (2) you fail to provide information requested by your insurance company (i.e. Coordination of Benefits [COB], etc.), or (3) we not receive payment from your insurance carrier more than 30 days after clean claim submission. A detailed receipt will be provided so that you may submit directly to your insurance company for reimbursement. Any overpayment to the Practice that may occur is promptly refunded.

Checks that return to us due to Non-Sufficient Funds (NSF) will incur an NSF charge added to original balance and result in our refusal to accept your checks in future.

A 24-hr advance notice of appointment cancellation is required. Established patients who miss a scheduled appointment will be charged a "NO SHOW" fee. As a courtesy to our patients, we make reminder calls 1-3 days prior to scheduled appointment. To cancel an appointment and/or leave a message after hours, dial 734/394-2661 and choose option 1. You can also send us an email via our website CONTACT tab. New Patient No Show's may result in our refusal to reschedule an appointment.

*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) within 10 days of receipt of invoice 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.*

Rev: AUG-19

(√)Patient Signature Print Name Relationship to Patient

(Parent/Guardian if Patient is a Minor)

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

Canton Asthma & Allergy
Pediatric & Adult Care
WEBSITE ADDRESS: www.CantonAllergy.com

STEVEN V. STRYK, MD, FAAAAI
**Canton Office: Tel 734/394-2661 - FAX: 734/394-2666**
1600 S. Canton Center Road, #360, Canton, MI 48188
**Novi Office: Tel 248/474-9661**

## HOW DO DEDUCTIBLES, COINSURANCE AND COPAYS WORK?

**DEDUCTIBLE.** A fixed $ amount the insured must pay during a given time period, usually a year, before their health insurance benefits will pay a claim.

**COINSURANCE.** Like a copayment, coinsurance is a form of cost sharing for health services or prescription drugs between insurance companies and the insured. Coinsurance means both you and your insurance company pay a portion of your medical expenses *after you've met your deductible*, based on your contracted amount.

**COPAY.** A copay is a fixed amount you pay for a health care service every time you go to the doctor. It may be defined in an insurance policy and paid by an insured person (usually a flat fee) to the provider of service *before receiving the service*.

**EXAMPLE:**

1. Your health plan has a $1,500 YEARLY deductible.
2. Your co-insurance contracted amount is 80%.
3. Your co-pay is $30 for your primary care doctor (PCP) / $40 for a specialist

Every time you see a doctor, you must pay a copay ($30 for PCP or $40 for Specialist) before being seen. Any services performed at that visit are then billed to your insurance carrier. Carrier may (or may not) write off some of the charges dependent upon what the doctor's office and health carrier have contracted as "reasonable and customary" for the services provided. You are then billed for the balance due. *This balance due amount is applied to your yearly deductible*.

Once you meet the $1,500 deductible for that year, coinsurance kicks in. Based on this example, your health plan would then pay 80% of your covered services and you are responsible for the other $20. You would still be required to pay your copay at each visit whether you have met your deductible or not.

Copay is NOT applied to your deductible. It is a flat rate due each time you see a doctor.

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

Appointment Date: Day: Time: Location:

| ***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, Famotidone (Pepsid) | 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 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 FAX: 734-394-2666
1600 S Canton Center, #360, Canton, MI 48188
Website: www.CantonAllergy.com

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**Steven V. Stryk MD, FAAAAI**

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

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 | | | | | |