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. No further services will be provided until the account is paid in full. Canton Asthma/Allergy accepts Cash, Check, Money Order, credit cards and Care Credit. You can also pay your bill on-line through our website.

An unpaid balance more than sixty (60) days overdue may be submitted to our Collection Company 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. The Fee is passed on to the patient balance due when submitted to collections. Once an account is submitted to collections, 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 have not received 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.

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. A courtesy reminder call is made to patients prior to the 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. No Call/No Show may result in our refusal to reschedule further appointments and may include discharge from our practice.

I understand and agree to the Financial Policy terms listed above. I received a copy of this Financial Policy for my records.

Rev: FEB 23

(√)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

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
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