

Allergy & Asthma Associates of Maine, P.A.
195 Fore River Parkway, Ste. 410
Portland, ME 04102
207-774-9839

An appointment has been made for _____ with Dr. Cardona/Chilmonczyk/Musmand/Denise
on _____.

Enclosed is the required New Patient paperwork. Even though all the questions may not seem pertinent, it is important that these forms are filled out as accurately as possible. This information will assist in determining your diagnosis and what mode of therapy to prescribe. **PLEASE BRING THESE FORMS WITH YOU ON THE DAY OF YOUR APPOINTMENT OR ARRIVE 15MINUTES EARLY.** Please have your physician send us any records regarding your reason for coming and any chest or sinus x-rays or CT scans from the past few years. **IF YOU ARE TO BE EVALUATED FOR EXERCISE INDUCED ASTHMA, PLEASE WEAR APPROPRIATE RUNNING SHOES.**

NEW PATIENT APPOINTMENTS MAY LAST FROM 2-3 HOURS DEPENDING ON THE AMOUNT OF TESTING DONE. WE HAVE THE RIGHT TO REFUSE TO SEE ANY PATIENT THAT IS MORE THAN 10 MINUTES LATE FOR THEIR APPOINTMENT.

If your problem is felt to be allergy related, testing may be done during your first visit. In order to get accurate results from the testing, certain medications need to be stopped. **MEDICATIONS TO BE STOPPED INCLUDE ALL ANTIHISTAMINES.** Below is only a partial list. If a medication is not listed and you are concerned that it may interfere with testing, please give us a call approximately one week before your appointment.

STOP 7 DAYS BEFORE APPOINTMENT (long acting antihistamines)

Alavert	Claritin	Claritin Redi-tabs	Hydroxyzine	Zyrtec Syrup
Allegra	Claritin Susp.	Fexofenadine	Loratadine	Zyrtec
Allegra-D	Clarinet	Tavist-ND	Zyrtec-D	Atarax
Claritin-D	Clarinet-D	Dimetapp-ND	Vistaril	Cetirizine

STOP 3 DAYS BEFORE APPOINTMENT (short acting antihistamine)

Astelin Nasal Spray	Chlorpheniramine	Chlor-Trimeton	Doxepin	
Astepro Nasal Spray	Triaminic	Advil PM	Tylenol PM	
Patanase Nasal Spray	Diphenhydramine	Drixoral	Optimine	
Tavist	Tavist-D	Nyquil	Sudafed Plus	Alka-Seltzer Plus
Allerest	Benadryl	Contac	Pediacare	Periactin

Please be aware that various sleep or cold medications contain antihistamines, and these need to be stopped as well.

Tricyclic antidepressants (e.g. amitriptyline), some psychiatric medications and certain ulcer medications (Zantac, Pepcid, Axid and Tagament) may affect skin testing. Many psychiatric medications need to be stopped 3-7 days before testing and most ulcer and reflux medications (except Prilosec, Prevacid, Omeprazole, Nexium, etc.) should be stopped 1 day before testing. Please contact your prescribing physician before stopping these medications. **If you have any questions, please call us.**

If you feel you cannot stop one of the above medications without becoming sick, you may remain on your medication.

Medications that need **NOT** be stopped prior to your appointment:

- Sudafed (pseudoephedrine)
- Oral and inhaled corticosteroids (e.g. Prednisone, Medrol, Vanceril, Azmacort, Beclovent, AeroBid, Pulmicort, Advair, Flovent, QVAR, Nasocort, Rhinocort, Vancenase, Flonase, Nasonex, Veramyst, etc.)
- Antibiotics
- Pure Theophylline preparations (e.g. Slo-Bid, Uniphyl, Theo-Dur, Quibron)
- Bronchodilator inhalers (e.g. Proventil, Ventolin, Serevent, Maxair, Atrovent, Foradil, etc.)
- Cromolyn Sodium (e.g. Intal) and Nedocromil Sodium (e.g. Tilade)
- Singulair

REGISTRATION FORM

1. PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Sex (circle): M F Patient SSN: _____ - _____ - _____ Date of Birth (mm/dd/yyyy): _____ / _____ / _____
Preferred Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____
In case of emergency call: Name: _____ Phone (____) _____ - _____ Relationship: _____

2. Responsible Party (Fill out if patient under age 18)

Mother/other
Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip _____
Home Phone (____) _____ - _____
Work Phone (____) _____ - _____
Cell Phone (____) _____ - _____
Relationship to Patient: _____

Father/other
Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip _____
Home Phone (____) _____ - _____
Work Phone (____) _____ - _____
Cell Phone (____) _____ - _____
Relationship to Patient: _____

3. Patient Employment Information

Employer: _____
Employer Address: _____
City: _____ State: _____ Zip _____

4. Referring Physician (This is the doctor who referred you to our practice)

Physician Name: _____
Practice Name (if any): _____
City: _____ State: _____ Zip _____
Phone (____) _____ - _____
Fax: (____) _____ - _____

DO YOU NEED A REFERRAL (Circle): YES NO

INSURANCE INFORMATION

Failure to complete this section may result in an inability to properly bill your insurance carrier. Please provide us with your insurance card at time of appointment

If you have a SECONDARY INSURANCE, you will need to complete the secondary insurance form on the back of this form.

1. PRIMARY INSURANCE POLICY INFORMATION:

Carrier: _____
Insurance Address: _____
City: _____ State: _____ Zip _____
Policy #: _____ Group #: _____

2. INSURANCE POLICY HOLDER (person whose employer carries the insurance policy).

Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip _____
DOB(mm/dd/yyyy): _____ / _____ / _____
SSN: _____ - _____ - _____ Sex (circle): M F
Home Phone (____) _____ - _____
Relationship to Patient: _____

3. POLICY HOLDER'S EMPLOYMENT

Employer: _____
Employer Address: _____
City: _____ State: _____ Zip _____

PRIMARY CARE PHYSICIAN of PATIENT (If same as referring physician, check this box)

Physician Name: _____
Practice Name (if any): _____
City: _____ State: _____ Zip _____
Phone (____) _____ - _____

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured/Guardian: _____ Date: _____ / _____ / _____

REGISTRATION

SECONDARY INSURANCE INFORMATION

*Failure to complete this section may result in an inability to properly bill your insurance carrier.
Please provide us with your insurance card at time of appointment*

1. SECONDARY INSURANCE POLICY INFORMATION:

Carrier: _____
Insurance Address: _____
City: _____ State: _____ Zip _____
Policy #: _____ Group #: _____

2. INSURANCE POLICY HOLDER *(This is the person whose employer carries the insurance policy).*

Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip _____
POLICY HOLDER DOB(mm/dd/yyyy): ____/____/____
SSN: ____ - ____ - ____ Sex (circle): M F
Home Phone (____) ____ - ____
Relationship to Patient: _____

3. POLICY HOLDER'S EMPLOYMENT

Employer: _____
Employer Address: _____
City: _____ State: _____ Zip _____

***** CONSENT FOR TREATMENT *****

TREATMENT

I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Signed: _____ Date: _____
Patient

Signed: _____ Date: _____
Patient or Parent/Legal Guardian

**FINANCIAL POLICY
FOR
ALLERGY & ASTHMA ASSOCIATES OF MAINE, P.A.**

Thank you for choosing Allergy & Asthma Associates of Maine, PA as one of your healthcare providers. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask if you have ANY questions about our fees or your financial responsibility.

Your initial consult will result in average charges between \$200.00 and \$800.00. The initial charges include a consult fee consisting of a detailed history and physical examination. There may also be fees for any testing (allergy skin testing and pulmonary function testing) that may be performed during the course of your visit here.

WE MAY ASK TO SEE YOUR INSURANCE CARD AT EVERY VISIT IN ORDER TO KEEP OUR INFORMATION CURRENT.

COPAYMENTS: Your insurance REQUIRES that we collect your assigned co-pay at the time of service. Please be prepared to **pay your co-pay at the time of your appointment.**

SELF-PAY: If you do not have insurance coverage, we are happy to work with you to set up a payment plan. If you are a new patient, \$100 will be expected prior to seeing the provider. Please contact the office to set up payment arrangements prior to your visit.

REFERRALS: If your insurance plan requires a referral from your Primary Care Physician, it is YOUR responsibility to obtain it prior to your appointment. If you do not have a valid referral on file, **you will be financially responsible for the visit.**

RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being charged a \$25.00 fee per returned check.

DIVORCE: In divorce situations, the parent who brought the child in is responsible for payment of the bill. We will file with any insurance company we have a contractual agreement with.

MONTHLY STATEMENTS: Any outstanding balance is due immediately upon receipt of statement. We accept payment by Visa, Mastercard, Discover or checks. Failure to pay your balance or set up payment arrangements within 90 days may result in the account being turned over to collections and the patient being discharged from the practice.

Please Note*** Your individual health insurance policy is a contract between you and your insurance company, and we are not a party to that contract. As a courtesy, we will submit your claim for all services to your insurance company. Be aware that some of our services may not be covered by your insurance company. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

Missed Appointments

We require 24 hours' notice on all cancelled appointments. New Patients that have missed an appointment will not be rescheduled and any established patients that miss more than one appointment may be discharged from the practice. Please help us serve you better by keeping scheduled appointments. Please realize that a missed appointment leaves an opening that could have been filled by a patient waiting to be seen in our office.

Patient Name: _____

PATIENT/PARENT SIGNATURE: _____ **DATE:** _____

INFORMATIONAL NOTICE ONLY



Patient Collection Policy

ALL BALANCES ARE DUE UPON RECEIPT

1. Your account will be considered past due thirty (30) days from the date of the first statement. This **does not** mean that your account has been sent to the collection agency, only that you need to give it your prompt attention.
2. **If you are unable to pay your balances in full, please call our Billing Department at 207-774-9839 ext. 205 to set up a payment arrangement. We are happy to set up a payment plan to fit your budget.**
3. We want to keep you as a patient, however, when your outstanding balance becomes **150 days past due without any payment** on account, the balance will be transferred to the Thomas Agency for further collection action and you will be discharged from the practice. You will need to contact them for payment options. Their contact information is:
The Thomas Agency
561 Forest Avenue
Portland, ME 04101
207-772-4659

Please read your statement messages, as they are important and will help inform you of your account status. If you continue to receive a statement that shows no insurance payments or adjustments, you need to contact our Billing Department at 207-774-9839, ext. 205.

Insurance companies have timely filing limits for all claims. The balance will be the patient's responsibility if the claim filing limit has been reached. Allergy & Asthma Associates will no longer be able to file those claims with your insurance company. Please present your **insurance card** to the receptionists at **each** visit and verify your *address, phone number and Primary Care Physician*. Having correct information on file will help avoid claim problems and allow us to contact you in a timely manner, should an issue arise.

Thank you,

The Billing Staff of Allergy & Asthma Associates, PA

**Allergy & Asthma Associates of Maine, PA
195 Fore River Parkway, Ste 410
Portland, ME 04102**

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I consent to Allergy and Asthma Associates of Maine, PA's use and disclosure of my protected health information (PHI) in support of my diagnosis and treatment, payment for the medical services I receive and the legitimate health care operations of the medical practice.

I consent to Allergy and Asthma Associates of Maine, PA's disclosure to other healthcare practitioners and facilities that are involved in providing medical services to me.

I understand that Allergy and Asthma Associates of Maine, PA's agreement to provide medical services is conditioned upon my signing of this consent and that Allergy and Asthma Associates of Maine, PA requests my consent to ensure that Allergy and Asthma Associates of Maine, PA can properly carry out the professional responsibility of caring for me.

I understand that Allergy and Asthma Associates of Maine, PA will disclose only the minimum amount of my health care information which is necessary, in the judgment of Allergy and Asthma Associates of Maine, PA for the legitimate needs of the recipient or for my general well being.

My PHI, which is the subject of this consent, includes demographic information, information about my physical or mental health condition, information about the medical services provided to me, including payment information if that information is required to identify me. Depending upon the medical services, I request or require, this information may include information about treatment for mental health or psychiatric conditions. I do request that this nor include treatment information for HIV/AIDS, sexually transmitted diseases or substance abuse unless a separate authorization form is signed by me ordering this information to be released.

I understand that I have a right to restrict Allergy and Asthma Associates of Maine, PA's use and disclosure of my PHI and that Allergy and Asthma Associates of Maine, PA is not obligated to agree to the requested restriction, but that an agreement to a restriction binds Allergy and Asthma Associates of Maine, PA. I may revoke this consent at any time by providing Allergy and Asthma Associates of Maine, PA with a written, signed and dated request except to the extent that Allergy and Asthma Associates of Maine, PA has acted in accordance to my consent.

However, I understand that any restriction on the use and disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

I acknowledge that this consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined above for 30 months from the date of this consent unless I revoke it earlier as described above.

I understand that Allergy and Asthma Associates of Maine, PA regards the safeguarding of PHI as an important duty. I understand, furthermore, that the elements of this consent are required by state and federal law for my protection and to ensure my informed consent to the use and disclosure of PHI necessary to support my relationship with Allergy and Asthma Associates of Maine, PA.

I have been offered a complete copy of the Allergy and Asthma Associates of Maine, PA Notice of Privacy Practices that provides a detailed description of the uses and disclosures addressed above and I have had the opportunity to review the Notice of Privacy Practices prior to signing this consent should I choose to do so. I acknowledge that Allergy and Asthma Associates, PA reserves the right to amend the Notice of Privacy Practices periodically. I understand that I may obtain a current copy of the Notice by contacting the office staff at any time.

I understand that if I have any questions about this consent or about Allergy and Asthma Associates of Maine, PA's privacy practices, or if I wish to have a copy of this consent, I may ask the office staff or my physician.

Patient Name

Date

Signature of Patient or Parent/Legal Guardian

I also authorize _____ whose relation to me is

_____ to access my PHI until I revoke this consent in writing.

NEW PATIENT-- QUESTIONNAIRE
Allergy & Asthma Associates of Maine
MUSMAND, MD; CHILMONCZYK, MD; CARDONA, MD, SIGLER, MD
www.allergyme.com

Name: _____
Date: _____
DOB: _____ AGE: _____ SEX: _____
Referring MD: _____
Primary Care MD: _____

Please complete this questionnaire and print and bring it with you to your scheduled visit.

REASON FOR YOUR VISIT TO OUR OFFICE:

PLEASE LEAVE THIS AREA BLANK.

CHEST SYMPTOMS: (Check here if NONE)

WHEN DID SYMPTOMS BEGIN? _____

HAVE YOU/YOUR CHILD BEEN DIAGNOSED WITH ASTHMA? _____

SYMPTOMS (CIRCLE): COUGH WHEEZE CHEST TIGHTNESS
SHORTNESS OF BREATH

SYMPTOMS WITH (CIRCLE): NIGHT-TIME ANIMALS EXERCISE COLDS
OTHER _____

ARE SYMPTOMS: DAILY? (times/day _____) or WEEKLY? (times/week _____)
NIGHT-TIME AWAKENING (times/month _____)

HOW MANY DAYS OF MISSED SCHOOL OR WORK IN PAST YEAR? _____

WORSE IN: YEAR-ROUND? SPRING? SUMMER? FALL? WINTER?

HOW OFTEN IS ALBUTEROL OR XOPENEX USED? _____ x Week

HOW OFTEN HAVE ORAL STEROIDS BEEN USED IN THE LAST YEAR? _____

EMERGENCY ROOM (ER) VISITS IN THE LAST YEAR? _____

HOSPITAL ADMISSIONS FOR ASTHMA? _____

EYES, EARS, NOSE, THROAT: (Check here if NONE)

WHEN DID SYMPTOMS BEGIN _____

SYMPTOMS (CIRCLE)? ITCHY RUNNY POST-NASAL DRIP
STUFFY ITCHY/WATERY EYES LOSS OF SMELL

WORSE IN: YEAR-ROUND? SPRING? SUMMER? FALL? WINTER?

SYMPTOMS WORSENERED BY: ANIMALS ODORS DUST OTHER? _____

TREATED FOR SINUSITIS? NUMBER OF TIMES IN THE PAST YEAR? _____

POLYPS and/or SINUS SURGERY? _____

NUMBER OF EAR INFECTIONS TREATED IN THE PAST YEAR? _____

TUBES? _____ TONSILLECTOMY? _____ ADENOIDECTOMY? _____

FOOD SYMPTOMS: (Check here if NONE)

WHICH FOODS? MILK EGG WHEAT SOY PEANUTS TREE NUTS
FISH/SHELLFISH OTHER _____

DESCRIBE SYMPTOMS _____

IF YES, TIME FROM INGESTION TO SYMPTOMS?

IMMEDIATE <10 Min <30 Min <2 Hrs >2Hrs 24 Hrs >24 Hrs

SKIN SYMPTOMS: (Check here if NONE)

SYMPTOMS: HIVES SWELLING ITCHING RASH

WHEN DID THEY START? _____

DESCRIBE HIVES, SWELLING OR RASH _____

IF HIVES, DO THEY LAST MORE THAN 24 HOURS OR LEAVE MARKS? _____

WHAT MAKES WORSE? _____

WHAT MEDICATIONS HAVE BEEN TRIED? _____

PAST MEDICAL HISTORY? (List):

PRIOR SURGERIES/HOSPITALIZATIONS

DATE: _____ DATE: _____

DATE: _____ DATE: _____

BIRTH HISTORY (IF CHILD):

BIRTH WEIGHT: _____ FULL TERM? _____ (IF NO, HOW MANY WEEKS EARLY? _____)
OXYGEN REQUIRED AFTER BIRTH? _____ BREATHING MACHINE AFTER BIRTH? _____

IMMUNIZATIONS: UP TO DATE? _____ FLU SHOT? _____ PNEUMONIA SHOT? _____

Chicken pox (varicella) vaccine OR had Chicken pox infection? _____

CURRENT MEDICATIONS: (including over the counter, herbal, etc):

DRUG ALLERGIES/ADVERSE REACTIONS: (NONE)

DRUG _____ REACTION _____
DRUG _____ REACTION _____
DRUG _____ REACTION _____

FAMILY HISTORY: (circle all that apply)

MOTHER: Asthma Hay fever Eczema Food allergy Hives Frequent infections Other _____
FATHER: Asthma Hay fever Eczema Food allergy Hives Frequent infections Other _____
SISTER(S): Asthma Hay fever Eczema Food allergy Hives Frequent infections Other _____
BROTHER(S): Asthma Hay fever Eczema Food allergy Hives Frequent infections Other _____

OTHER CHRONIC CONDITIONS:

Cystic fibrosis _____ COPD/Emphysema _____ Autoimmune Disease _____
Other _____

SOCIAL HISTORY: (circle all that apply)

MARITAL (OR PARENTS') STATUS: Single Married Divorced Widow

SMOKER? Y / N PACKS/DAY _____

OCCUPATION? _____

SCHOOL? Y / N (WHAT GRADE? _____)

HOBBIES? Y / N (IF YES, WHAT? _____)

DAY CARE? Y / N (DAYS A WEEEK _____)

ENVIRONMENT:

INDOOR/OUTDOOR PETS? CATS (#. ____) DOGS (#. ____) BIRDS (#. ____) OTHER _____

AGE OF HOUSE _____ YEARS AT RESIDENCE _____ TYPE OF HOUSE _____

ANYONE SMOKE AT HOME? _____ PACKS/DAY _____

DO YOU HAVE: (Circle if positive)

BEDROOM CARPETTING? STUFFED ANIMALS? DUST MITE COVERS?

HUMIDIFIER? DAMP BASEMENT? WATER DAMAGE/FLOODING?

FORCED AIR HEAT? WOOD HEAT? FIREPLACE? AIR CONDITIONING?

Other concerns you have about the home _____

OTHER CONDITIONS: (check here if all are negative; circle if present):

Fever Night sweats Weight loss Fatigue Swollen glands Anemia
Easy bruising Headaches Seizures Vision loss Hearing loss Hoarseness
Palpitations Chest pain Difficulty swallowing Vomiting High blood pressure
Heartburn Belly pain Choking on food/liquid Diarrhea Constipation
Bloody stools Joint pain/swelling Osteoporosis Anxious Depressed
Other _____

Other Information that you want the doctor to know:

PLEASE LEAVE THIS AREA BLANK.