ALLERGY ASTHMA, & IMMUNOLOGY ASSOCIATES, P.C.
2808 S. 80TH AVE. STE. 210 OMAHA, NE 68124
Phone (402) 391-1800

Welcome New Patient,

Thank you for making an appointment with Allergy, Asthma & Immunology Associates, and for your confidence in our physicians and staff, to meet your health needs. The physicians in our practice are board-certified specialists in adult and pediatric allergy, asthma, and immunology; to provide you with the highest level of care, your initial visit could last from one to three hours.

Our usual evaluation fee is $350.00 (CPT code 99204). This amount does not include charges for allergy or lung function tests, or other tests/procedures performed at our office. Skin tests cost $15.00 for each scratch test (code 95004) and $17.00 for each intradermal test (code 95024). Complex allergy cases may require as many as 75 tests for proper evaluation. Lung function tests range from $75.00 to $150.00. Not all patients need skin or lung function tests. (Fees are subject to change without notice.)

Please discontinue the use of Alavert, Allegra, Astelin Nose Spray, Atarax, Axid, Benadryl, Claritin, Pepcid, Tagamet, Zantac, or any other antihistamine 5 days prior to your appointment. Discontinue Clarinex or Zyrtec 7 days prior to your appointment. Do not stop asthma medications.

IMPORTANT REMINDERS BEFORE YOUR APPOINTMENT:

- Please complete and sign all patient forms in the packet; bring the forms to your appointment.
- Included in the packet is AAIA's Financial Matters policy; please review it thoroughly.
- Please bring all insurance cards (primary/secondary/tertiary coverage).
- Please bring payment for your office visit co-payment amount ("specialist" co-pay).
- We submit your claims to your insurance company; if you wish to file your own insurance claim, then full payment is due at the time of service.
- If you have Medicare or Medicaid, we will automatically submit your charges.
- Payment of your remaining balance, after insurance has processed, is due upon receipt of your statement. You may pay by cash, check, or credit/debit card. Payment plans are available. We also accept CareCredit® - please call our Billing Office for details.

Please arrive 15 minutes prior to your appointment, for check-in. Your appointment is important to us, so please call us at (**402) 391-1800** at least **24 hours** in advance if you are unable to keep your appointment, so we may offer the time slot to another patient. We appreciate your cooperation.

Please contact our office if you have any questions. We look forward to caring for you.

Sincerely,

The Physicians and Staff of Allergy, Asthma & Immunology Associates, P.C.

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Please complete forms on the following pages.

FINANCIAL MATTERS

Allergy, Asthma & Immunology Associates, P.C. of Omaha and Lincoln is extremely pleased to provide care to you and your family. The following details outline our clinic's financial policy:

- We must emphasize that as a medical practice, our relationship is between you and our physicians, not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, it is often necessary for you to inquire and explore your benefits with your insurance carrier. The patient is responsible for any portion of the charges deemed non-covered or noted as "Patient Responsibility".

- AAIA is a private practice (independent) clinic. AAIA is not directly affiliated with outside laboratories, clinics, pharmacies, or physicians; when AAIA physicians write lab orders, our physicians are not liable for the charges, fees, and bills you may receive when you have services or labs drawn through these non-AAIA entities. AAIA emphasizes that new and established patients must: a) check with their specific insurance plan to determine which of AAIA's physicians and locations are "in-network" for their benefits; b) check in advance with their insurance plans to determine coverage and exclusions; c) check in advance with laboratories, non-AAIA physicians, and pharmacies, to understand the services, charges, and patient financial responsibilities that they will have with the non-AAIA entities.

- The patient is required to present an insurance card(s) at each visit. Failure to provide this information may result as a "self pay" patient. If you have no insurance coverage or your charges are subject to a large yearly deductible, a minimum down payment of $200.00 towards the balance is expected at the time of your visit if you are a NEW patient. A minimum down payment of $100.00 towards the balance is expected at the time of your visit if you are an ESTABLISHED patient. Per the No Surprises Act of 2022, if you would like a Good Faith Estimate of the costs for services/procedures anticipated to be rendered, please contact our Business Office. Additionally, our Business Office will contact you to establish a formal payment plan for the remaining balance.

- Our office files all insurance claims, however, we may not be participating providers for all insurance plans**. It is your responsibility to check with your insurance payer before your visit to see if AAIA is in network with your plan. Services listed as "covered" by your plan, are still subject to the patient financial liability for their deductibles, co-insurance, and co-payments (as outlined in your plan).**

- **Note that when referring to your plan benefits and coverage, the physicians, and mid-levels (physician assistants, nurse practitioners) at our clinic, are categorized as specialists.**

Over ⇨

- All co-payments are due at the time of service, including injection patients who have a co-payment/co-insurance payments associated with each administration injection.

- If your insurance provider requires a referral, such as Tricare Prime members, **you** are responsible for getting a referral to our office from your primary care (PCP) doctor. This must be done no later than **48 hours** prior to your appointment. We follow guidelines set forth in those plans and services cannot be rendered if proper authorization has not been given. Please have your referring doctor fax the referral to (402) 391-1563 or call (402) 391-1800.

- Once the insurance company has processed the claim, you will receive a billing statement which shows the patient responsibility portion of your services.

    - Payment in full is expected when you receive your statement. Checks or credit card payments may be mailed to our Billing Office at 2808 S 80 Ave Ste 210 Omaha NE 68124. Payments in cash or by check are accepted in person at all locations.

    - Payments by credit card (Visa®/MasterCard®/Discover®/American Express®) are accepted in person or over the phone by calling our Billing Office at 402-391-1800.

    - If you are unable to pay your balance in full at the time you receive your statement, please call and speak with one of our billing staff to set up a monthly payment plan. We also accept CareCredit®; please call our Billing Office if you would like details.

    - A $50 Service Fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pay cash, money order, or credit card for the services.

I understand and agree to the terms of this Financial Policy:

_____

Signature of patient/Responsible party

_____

Print patient name/Responsible party

_____

Date

PATIENT DEMOGRAPHIC FORM **DATE:_____**

LAST NAME:_____FIRST NAME:_____MIDDLE INITIAL:_____

DATE OF BIRTH:_____AGE:_____SOCIAL SECURITY NUMBER:_____ GENDER: MALE ◯ FEMALE ◯

MARITAL STATUS: MARRIED ◯ SINGLE ◯ SEPARATED ◯ DIVORCED ◯ WIDOWED ◯ LIFE PARTNER ◯

RACE (FOR LABORATORY PURPOSES): WHITE ◯ BLACK OR AFRICAN ◯ AMERICAN INDIAN OR ALASKAN NATIVE ◯

ASIAN ◯ HISPANIC ◯ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ◯

PREFERRED LANGUAGE:_____

HOME OR MAILING ADDRESS:

_____APT#:_____CITY:_____STATE:_____ZIP CODE:_____

CELL PHONE: _____ **HOME PHONE:** _____

EMAIL ADDRESS:_____

REFERRING PHYSICIAN/ADDRESS/PHONE:_____

PRIMARY CARE PHYSICIAN/ADDRESS/PHONE:_____

THE FOLLOWING IS REQUIRED IF PATIENT IS A MINOR: PARENT(S) OR LEGAL GUARDIAN(S)

MOTHER NAME:_____DOB:_____ FATHER NAME:_____DOB:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____POLICY NUMBER:_____GROUP#:_____
SUBSCRIBER:
LAST NAME:_____FIRST NAME:_____MIDDLE INITIAL:_____DOB:_____
RELATIONSHIP TO PATIENT: SELF ◯ SPOUSE ◯ PARENT ◯ OTHER ◯

SECONDARY INSURANCE COMPANY:_____POLICY NUMBER:_____GROUP#:_____
SUBSCRIBER:
LAST NAME:_____FIRST NAME:_____MIDDLE INITIAL:_____DOB:_____
RELATIONSHIP TO PATIENT: SELF ◯ SPOUSE ◯ PARENT ◯ OTHER ◯

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

FIRST NAME:_____LAST NAME:_____PHONE NUMBER:_____

RELATIONSHIP TO PATIENT:_____

PLEASE READ AND SIGN

I hereby authorize James M. Tracy, DO, Brett V. Kettelhut, MD, James L. Friedlander, MD, & Robert Szalewski, MD to furnish to the insurance company(s) information regarding me or my child's health and treatment. I also hereby assign to the doctor all payments for medical services provided to my dependents or me. I understand that to the extent allowable by law, that I am responsible for any amount whether or not covered by insurance program, Preferred Provider Organization (PPO), any Health Maintenance Organization (HMO), or any other provider of medical coverage.

PATIENT (SUBSCRIBER) SIGNATURE:_____DATE:_____

I request that payment of authorized MEDICARE payments be made to Allergy, Asthma & Immunology assoc., P.C., for any services furnished to me by Allergy, Asthma, & Immunology Assoc., P. C. I authorize the holder of medical information pertaining to me, to release to MEDICARE and its agents, information needed to determine these benefits or the benefits payable for related services.

MEDICARE AUTHORIZATION

SIGNATURE:_____DATE:_____

In the event that my child/children should require medical care or treatment and my husband/wife and I should be unavailable or out of town, I give permission to James M. Tracy, DO, Brett V. Kettelhut, MD, James L. Friedlander, MD, & Robert Szalewski, MD, to care for my child/ren as these physicians deem necessary.

PARENT/LEGAL GUARDIAN SIGNATURE:_____DATE:_____

PLEASE PAY CO-PAY AT THE TIME OF EACH VISIT

IF YOUR INSURANCE PLAN REQUIRES A REFERRAL, YOU MUST HAVE THE REFERRAL BEFORE YOUR VISIT. (NEW & FOLLOW-UPS)

Allergy, Asthma & Immunology Associates, P.C.

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Please complete forms on the following pages.

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

- A basis for planning my care and treatment
- A means of communication among the any health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that if have the right to object to the use of my health information directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis, (including treatment, payments, and health care options).

_____

_____

Please list the family members or significant others, if any, whom we may inform about your medical condition only in emergency.

_____

_____

Please list telephone numbers where we may reach you and leave general messages, for example, "Please call John at Dr.Tracy's office"

HOME_____

WORK_____

CELL_____ (Please be aware a cell phone is not a secure line)

_____ _____

Signature of Patient or Legal Representative Witness

_____ *August 20, 2012*

Date Notice Effective Date or Version

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Please complete forms on the following pages.

Allergy, Asthma & Immunology Associates, P.C.

☐ Dr. Kobayashi ☐ Dr. Tracy ☐ Dr. Kettelhut ☐ Dr. Friedlander

Allergy Questionnaire

Patient Name: _____ Date of Appointment: _____
Date of Birth: _____ Referring MD: _____
Race ☐ White ☐ Black or African ☐ American Indian or Alaskan Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic
(Race will be used for laboratory purposes)

1. What is your major problem(s) / chief complaint which brought you here? _____
_____
_____

2. What symptom(s) bothers you the most?

☐ Nasal Congestion	☐ Runny Nose	☐ Itchy/Red/Watery eyes	☐ Headache
☐ Sinus Pain and Pressure	☐ Drainage	☐ Shortness of Breath	☐ Itchy Skin
☐ Ear Pressure / Fluid	☐ Sneezing	☐ Cough	☐ Rashes
☐ Itchy Ears	☐ Itchy Throat	☐ Fatigue	☐ Hives(welts)

3. How long have you had these symptoms? _____ weeks _____ months _____ years

4. Do your symptoms seem to occur *(mark all that apply):*
☐ All year round ☐ Seasonally only
☐ Indoors ☐ Outdoors
☐ With foods _____ ☐ With medicines _____
☐ Other: _____

5. Any known allergies to medications/vaccines? ☐ No ☐ Yes _____
Any known allergies to foods? ☐ No ☐ Yes _____
Any known allergies to insects? ☐ No ☐ Yes _____
Any known allergy to latex? ☐ No ☐ Yes

6. List ALL your medications/supplements *(include any creams, inhalers, sprays)*
Include dose and frequency. **PHARMACY: _____**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

7. List any medications that have NOT been helpful or caused adverse side effects?

_____ _____

_____ _____

8. How many days since you have taken an antihistamine(s)? _____

9. Please list any of your other diagnoses/ health problems *(i.e. high blood pressure, diabetes, heart conditions, cancer, thyroid problems, arthritis, depression, anxiety. eczema*)

_____

_____

10. Past Surgical History: ☐ None

☐ Tonsillectomy *Date:* _____ ☐ Adenoidectomy *Date*:_____

☐ Sinus Surgery *Date*:_____ ☐ Ear Tubes *Date*: _____

Please list all other surgeries:

_____

_____

11. Are your immunizations up to date? ☐ No ☐ Yes

☐ Pneumovax - *when?* _____

☐ Prevnar13 - *when?* _____

12. Family History *(mark applicable):*

☐ Allergies ☐ Asthma ☐ Eczema (skin allergy condition)

☐ Food Allergies ☐ Hives (welts) ☐ Angioedema (swelling condition)

☐ Immune deficiencies ☐ Upper respiratory Infections

13. Social History *(mark applicable):*

☐ No history of tobacco use ☐ Secondhand exposure

☐ Previous tobacco use _____packs/per day for _____ (total number) years

☐ Current tobacco use _____packs/per day for _____ (total number) years

☐ Social alcohol use ☐ Daily alcohol use ☐ Never any alcohol use ☐ History of alcohol abuse

☐ Recreational drug use (i.e. *marijuana*) _____ ☐ None

14. Environmental Living:

Occupation: _____

☐ Living in private residence ☐ Living in apartment ☐ Other _____

☐ Country/farm ☐ Suburb ☐ City

Regular exposure to:

☐ Carpets in bedroom ☐ Plants indoors ☐ Cockroaches

☐ Cigarette Smoke ☐ Dampness/mold ☐ Irritants

☐ Animal - *what kind?* _____

15. Have you previously had allergy testing? ☐ No ☐ Yes *when? where*? _____
☐ Weeds ☐ Trees ☐ Grasses ☐ Molds ☐ Dust Mites
☐ Animals ☐ Foods ☐ Medicines ☐ Other _____
Have you previously been on allergy shots? ☐ No ☐ Yes *when?* _____

TROUBLE BREATHING / CHRONIC RESPIRATORY DISEASE, proceed with the following questions:

1. Describe symptoms:
☐ Wheezing ☐ Shortness of Breath ☐ Chest tightness ☐ Chest pains
☐ Coughing ☐ Nighttime Coughing ☐ Other: _____

2. How long have you had these symptoms? ____ weeks ____ months ____ years
Is it getting worse? ☐ Yes ☐ No

3. How often do these symptoms occur?
every_____ day(s) every_____ week(s) every_____ month(s)
☐ Only with triggers ☐ Multiple times a day

4. Which factors seem to make your breathing worse:
☐ Coughing ☐ Cold Air ☐ Exercise ☐ Laughing ☐ Fragrances/ Fumes
☐ Viruses ☐ Weather Changes ☐ Pollen ☐ Animals ☐ Smoke
☐ Other: _____

5. Related to your respiratory problems, have you:
☐ been hospitalized ☐ gone to the Emergency Room ☐ had to see a previous doctor
Explain: _____
_____

6. What medications have you taken in the last year?
Rescue Inhaler: ☐ ProAir ☐ Proventil ☐ Xopenex ☐ Combivent ☐ Ventolin
Daily Scheduled Inhaler: ☐ Advair ☐ Flovent ☐ Qvar ☐ Asmanex
☐ Breo ☐ Symbicort ☐ Pulmicort ☐ Other_____
Other Medication: ☐ Singulair ☐ Prednisone - *How many courses?* _____
☐ Steroid injection_____

7. Do you use: ☐ BiPaP ☐ CPaP ☐ Supplemental Oxygen

8. Are there any inhaler medications you cannot take? _____
_____

Dr. Signature _____ Date _____