Carolina Allergy & Asthma Consultants

Jonathan G. Black, M.D.
Michael J. Bykowsky, M.D., Ph.D.
David Perrick, M.D.
Robert A. Vande Stouwe, M.D., Ph.D.

## PERSONAL INFORMATION - ADULT

| PATIENT'S LAST NAME | FIRST | NICKNAME | MIDDLE | ☐ MALE ☐ FEMALE |
|---|---|---|---|---|
| STREET ADDRESS | CITY | STATE ZIP | EMAIL | |
| DATE OF BIRTH | AGE | SOCIAL SECURITY# | HOME TELEPHONE | CELL PHONE | BUSINESS TELEPHONE |
| MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ SEPARATED | OCCUPATION | REFERRED BY: | | |
| IN CASE OF EMERGENCY, NAME OF PERSON TO CONTACT (NOT LIVING WITH YOU) | | | TELEPHONE | |
| PRIMARY CARE PHYSICIAN | ADDRESS | CITY | STATE | ZIP | TELEPHONE |
| PREFERRED PHARMACY | ADDRESS | CITY | STATE | ZIP | TELEPHONE |
| PREFERRED LANGUAGE | ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC ☐ REFUSE TO ANSWER | RACE ☐ WHITE ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN | | |

## SPOUSE INFORMATION

| LAST NAME | FIRST | MIDDLE | SOCIAL SECURITY # / DATE OF BIRTH | HOME TELEPHONE | CELL PHONE |
|---|---|---|---|---|---|
| STREET ADDRESS | CITY | | STATE | ZIP | |
| EMAIL | | | | | |

## INSURANCE INFORMATION

| NAME OF INSURANCE COMPANY (PRIMARY) | POLICY NO. / ID NO. | NAME OF INSURED / RELATIONSHIP TO PATIENT |
|---|---|---|
| ADDRESS TO SEND CLAIMS | GROUP NO. & NAME | POLICY OWNER'S DATE OF BIRTH / EFFECTIVE DATE OF POLICY |
| NAME OF INSURANCE COMPANY (SECONDARY) | POLICY NO. / ID NO. | NAME OF INSURED / RELATIONSHIP TO PATIENT |
| ADDRESS TO SEND CLAIMS | GROUP NO. & NAME | POLICY OWNER'S DATE OF BIRTH / EFFECTIVE DATE OF POLICY |

## FINANCIAL POLICY

Payment of medical fees is the responsibility of the patient. Should we file your insurance for you it is your responsibility to pay us any deductible, co-insurance, or any other balances not paid by your insurance at the time of service. If we are filing your insurance, it is your responsibility to provide us with completed and signed insurance claim forms or any pre-authorization forms that are needed.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of medical benefits to Carolina Allergy & Asthma Consultants for services rendered. I also authorize the release of any medical information to process insurance claims. I acknowledge the responsibility to pay any debt incurred during my treatment, including attorney fees, legal fees and court costs.

SIGNED (INSURED OR RESPONSIBLE PERSON) _____ DATE _____

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# Notice of Privacy Practices

*To our patients: This* notice describes how health information about you as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

## Use and disclosure of your health information in certain special circumstances

**The following circumstances may require us to use or disclose your health information:**

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military force (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

## Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact us at (803) 929-0290.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our privacy officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact us.

I hereby acknowledge that I have been presented with a copy of Carolina Allergy & Asthma Consultants' Notice of Privacy Practice.

_____ _____

# Carolina Allergy & Asthma Consultants

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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that I have been given an opportunity to review the privacy practices at Carolina Allergy & Asthma. I understand that I may obtain a copy of the Notice of Privacy Practices.

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

_____ _____

Signature of Patient/Representative and Relationship to Patient Date

_____ _____

Signature of Practice Representative Date

**Parkridge**
100 Palmettto Health Parkway, Ste. 340
Columbia, SC 29212
(803) 407-0701

**Downtown-Columbia**
One Richland Medical Park, Ste. 200
Columbia, SC 29203
(803) 929-0290

**Northeast**
Northeast Medical Center, Ste. 113
115 Blarney Drive
Columbia, SC 29223
(803) 788-8603

# UNIVERSAL MEDICATION FORM

**Date form started:**

| **Name:** | **Address:** |
|---|---|
| **Phone Number:** | |
| **Birth Date:** | |
| **Emergency Contact/Phone numbers:** | |

| **IMMUNIZATION RECORD** (Record the date/year of last dose taken, if known) | | |
|---|---|---|
| TETANUS | FLU VACCINE(S) | |
| PNEUMONIA VACCINE | HEPATITIS VACCINE | OTHER |

| **Allergic To /Describe Reaction:** | **Allergic To /Describe Reaction:** |
|---|---|
| | |
| | |
| | |

**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).**

| DATE | NAME OF MEDICATION / DOSE | DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.) | DATE STOPPED | Notes: Reason for taking / Doctor Name |
|---|---|---|---|---|
| | | | | |
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## COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name (Print): _____ Date of Birth:_____

Social Security Number: _____ Chart #:_____

Verified by: _____

Carolina Allergy & Asthma Consultants (CAAC), is authorized to release protected health information about the above named patient to the person(s)/entity(ies) named below. The purpose is to inform the patient or others authorized by the patient about the matters indicated. Release can be by: **(Check all that apply):**

❑ Pick Up only ❑ Mail ❑ Fax ❑ Telephone

| **Person or entity Authorized to Receive Information**<br>(Check each person/entity that you approve to receive the information indicated in the opposite column.) | **Description of Information to be Released**<br>(Check each that can be released to the person/entity on the left column in the same section of this table.) |
|---|---|
| ❑ Leave on voice Mail/Answering Machine | ❑ Results of Lab test / X-rays<br>❑ Appointment Information / Reminders<br>❑ Other (Explain): _____ |
| ❑ Give Information to employer<br>❑ Give Information to school | ❑ Appointment absentee information |
| ❑ Spouse | ❑ Medical Information (Explain if limited): _____<br>_____<br>_____<br>❑ Family billing information<br>❑ Financial information<br>❑ Appointment information |
| ❑ Parent/Other Family Member (provide name/ relationship): _____<br>Relation: _____ | ❑ Medical Information (Explain if limited): _____<br>_____<br>_____<br>❑ Family billing information<br>❑ Financial information<br>❑ Appointment information |
| ❑ Other (provide name): _____ | ❑ Medical Information (Explain if limited): _____<br>_____<br>_____<br>❑ Family billing information<br>❑ Financial information<br>❑ Appointment information |
| ❑ Support Group (provide name and point of contact): | ❑ Demographic information |

I understand I may revoke this authorization at any time by submitting a written revocation letter to CAAC. This letter must be addressed to the Practice Administrator, One Richland Medical Park, Suite 200, Columbia, SC 29203. I further understand that any revocation will not be effective in cases where to information has already been disclosed but will be effective going forward from the receipt of the revocation.

I understand that CAAC will not condition my treatment of payments on whether I provide this authorization.

Any medical information received by the practice pursuant to this authorization will be protected under the provisions of the Health Improvement Portability and Accountability Act of 1996 Privacy Standards (HIPPA). I further understand that during facsimile transmission there is a possibility that these records may inadvertently go to a party other than the one intended and that CAAC cannot guarantee th confidentiality of these records. I also understand the information used and disclosed as a result of this authorization may be subject to redisclosure by the recipient and my no longer be protected by federal or state law.

Patient's (or Authorized Representative's) Signature: _____ Date:_____

Description of Personal Representatives Authority (attach a copy of legal documentation): _____

_____

***This authorization will remain in effect until revoked unless I specify a date.*** I choose to specify that this authorization expire at midnight on _____ (date).

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Patient's Name: _____ Date of Birth: _____ Date: _____

**PLEASE COMPLETE THE FOLLOWING PATIENT HISTORY QUESTIONNAIRE**

Feel free to make additional comments. Base your answers on your own observation and not on what you have been told by others or what you may know about previous skin test results.

**(CIRCLE ONE)**

I. MAJOR PROBLEM: **(asthma, wheezing, nose, rashes, eczema, hives, ears, eyes, stomach)**

a) At What Age Did The Problem Begin?_____

b) Is The Problem Getting: **(better, worse, staying the same)? CIRCLE ONE**

c) How Frequent Are The Symptoms? _____

d) How Long Do The Symptoms Last? _____

e) What Do You Think Starts The Symptoms Or Makes Them Worse? _____

_____

f) Are The Symptoms The Same All Year Round? ____Yes ____No

g) Symptoms Worse? **CIRCLE**

**(Jan., Feb., Mar., Apr., May, Jun., Jul., Aug., Sep. Oct., Nov., Dec.).**

h) Symptoms Worse? **(early morning, afternoon, evening, night time).**

i) Symptoms Worse? **(outside, indoors, at home, at school, other places).**

j) Symptoms Worse Any Place You Have Traveled? _____

Better Anywhere? _____ **CIRCLE**

k) Has The Patient Ever Been Hospitalized For: **asthma, pneumonia, bronchitis, or bronchiolitis?**

____Yes ____No, If yes, How many times?____ patients age(s) at that time____

l) Has The Patient Ever Been Seen In The Emergency Room For Asthma? ____Yes ____No

If yes, How often?_____ When last?_____ Where?_____

II. SYMPTOMS: Please **Circle** Any Problems Listed Below That The Patient Has:

Nose: **sneezing, itching, stuffiness, sinus, mouth breathing, discharge, bleeding**

Throat: **sore, post-nasal discharge, mouth breathing, snoring, bad breath, hoarseness**

Eyes: **itching, burning, red, puffy, discharge, dark circles, headache**

Ears: **recurrent ear infections, poor hearing, fluid in ear, popping, fullness**

Skin: **hives, eczema, itching, dry skin, rashes, swelling**

Chest: **cough, sputum, wheezing, pain, breathlessness after exercise, rattles**

Digestive: Any Problems With: **infant formulas (milk), colic in infancy, constipation, stomachache loose stool, gas, belching, formula changes, heartburn/reflux**

Additional Comments: _____

a) Are Symptoms Worse After The Patient Is Exposed To Any Of The Following? **CIRCLE**

Dust: **house dust, outdoor dust, air pollution**

Cosmetics: **sprays, soaps, bubble bath**

Fabrics: **pillows, feather, wool, polyesters, other** _____

Plants: **grass, trees, cutting lawn, flowers, weeds, pine straw, raking leaves**

Climate Changes: **winds, heat, cold, dryness, dampness, drafts, sun, air conditioning**

Emotional Factors: **stress, anger, fear, fatigue**

Infections: **colds, flu, bronchitis, other** _____

Smoke: **tobacco, automobile, other** _____

Animals: **dogs, cats, horses, birds, rabbits**

b) Does Exercise Or Activity Increase Symptoms? _____Yes _____No

c) Do Any Foods Increase Symptoms Or Disagree With The Patient? _____Yes _____No

List foods and problems they cause: _____

_____

d) Has The Patient Had Any Reactions To Medicines? _____Yes _____No

List the medicines and the problems they cause: _____

_____

e) Has The Patient Had Any Reactions To Insect Bites Or Stings? _____Yes _____No

List the insects and the problems they have caused: _____

_____

III. PERSONAL ENVIRONMENT:

a) Has Patient Lived In Present Home All Of Their Life? ____Yes _____No How Long? _____

If no, date of last move _____ From where? _____

Are the symptoms: **better, worse, the same,** since the move? **CIRCLE**

b) Does The Patient Spend Much Time In More Than One Home? _____Yes ____No

If yes, where? _____

c) Does Anyone Smoke At Home? _____Yes_____No Who? _____

d) Does patient presently smoke? _____Yes _____No Amount (circle)
1/4 1/2 3/4 1 2 ppd

Did you ever smoke? _____Yes _____No

(If applicable) When did you quit? _____years ago.

e) Patient's occupations _____ (f) Hobbies _____

f) Do you Use a Vaporizer Or Humidifier? _____Yes _____No Where?_____

g) Please **Circle** The Following Answers:

Type of Heating: **gas, electric, central heat, floor furnace, wood stove**

Air Conditioning: **central, window units** Filter: **permanent, disposable** How often changed or cleaned? _____

h) What Pets or Birds Do You Have? _____

When did you get them? _____ Where do they sleep? _____

i) Did you visit friends/relatives who have: **cats, dogs, rabbits, horses, birds**

j) Patient's Bedroom:

Mattress type and age: _____ Zippered mattress cover? _____Yes _____No

Pillow: _____**feather,** _____**foam,** _____**dacron,** _____**non-allergenic**

Blankets or Quilts: _____**wool, other**_____

Drapes: _____ Are windows kept closed all year? _____Yes _____No

Dust Collecting Items: _____**many books** _____**stuffed chair** _____**stuffed animals**

_____**wall-to-wall** _____**throw rug** _____**shag**

Plants: _____

h) Your Yard/Neighborhood:

Type of lawn: _____ Cut by whom? _____ Kind of trees? (yours and close neighbors):_____

Are there any unpaved streets? _____Yes _____No

**Circle** Any of the following, if present: **factories, smelters, grain elevators, farms, stables, open field**

i) Crawl Space Under the House: _____**damp** _____**musty** _____**dry**

## IV. MEDICATIONS:

a) **Circle** Any Of The Following Medicines That The Patient Has Taken, And Then **Check** The Appropriate Line:

| | | | |
|---|---|---|---|
| **Aminophylline or theophylline medicines** | Was the patient: ___better? | ___worse? | ___same? |
| **Inhalers, type?** _____ | Was the patient: ___better? | ___worse? | ___same? |
| **Antihistamine/Decongestants** | Was the patient: ___better? | ___worse? | ___same? |
| **Steroids:** | Was the patient: ___better? | ___worse? | ___same? |

b) List All Medications That The Patient Takes **NOW**, State Whether They Relieve The Symptoms.

_____

_____

_____

_____

c) If The Patient Is A Child, Does He Or She Take Gym At School? _____Yes _____No

If no, why? _____

d) Does The School Allow Your Child To Take His Or Her Medicine? _____Yes _____No

e) Number of School/Work Days Missed This Year? _____

V. PERSONAL HISTORY: Has the patient ever had:

a)

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ___ | ___ | **Chest X-Ray** (Date _____ ) | ___ | ___ | **Sinus CT** (Date _____ ) |
| ___ | ___ | **Ear Fluid** | ___ | ___ | **Bronchitis** |
| ___ | ___ | **Recurrent Ear Infections** | ___ | ___ | **Pneumonia** |
| ___ | ___ | **Ear Tubes** | ___ | ___ | **Recurrent Sinusitis** |
| ___ | ___ | **Tonsils/Adenoids Removed** | ___ | ___ | **Sinus Surgery** (Dates_____) |
| ___ | ___ | **Previous Allergy Tests** If yes, date _____ by whom _____ | | | |
| ___ | ___ | **Allergy Injections** If yes, how long _____ Doctor _____ | | | |

What effects did these have on the patient's problems? _____

b) Other doctors who have cared for the patient: _____

_____

c) Please list any other medical problems and medications you take for them:

_____

_____

_____

_____

VI. FAMILY HISTORY: (Patient's Parents, Brothers and Sisters, Grandparents, Aunts, Uncles, Cousins)

| | YES | NO | WHO (Relation) |
|---|---|---|---|
| a) Is There A History of **Asthma?** | ___ | ___ | _____ |
| b) Is There A History of **Hay Fever?** | ___ | ___ | _____ |
| c) Is There A History of **Sinus Trouble?** | ___ | ___ | _____ |
| d) Is There A History of **Hives?** | ___ | ___ | _____ |
| e) Is There A History of **Eczema?** | ___ | ___ | _____ |
| f) Is There A History of **Drug Allergies?** | ___ | ___ | _____ |
| g) Is There A History of **Food Allergies?** | ___ | ___ | _____ |

PERSON COMPLETING THIS FORM: RELATIONSHIP TO PATIENT TODAY'S DATE

_____ _____ _____

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## MISSED APPOINTMENT POLICY

We want to thank you for choosing CAAC as your health care provider. We ask you to arrive 15 minutes early for your appointment so we can ensure that all allergy history forms and authorizations are obtained. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments.

**A missed appointment is when you:**

- **Fail to show up for your allotted appointment time**
- **Fail to cancel an appointment at least 24 hours in advance**
- **Are more than 15 minutes late for your appointment**

Please remember that we have reserved the appointment time especially for you. Therefore, we request at least a 24 hour if you need to cancel. This will enable us to offer your cancelled time to other patients who are in need of care.

If you are unable to keep your scheduled appointment time, ***please call our office at least 24-hours in advance in order to avoid a $25 missed appointment fee***. **This fee is not covered by insurance**. Your phone call is critical in helping us provide continuous care to all of our valued patients. If you fail to give us notice of your missed appointment, you will be charged the fee.

have read and understand the policy stated above:

_____

gnature

_____

Date

**Parkridge**
100 Palmetto Health Pkwy Ste 340
Columbia, SC 29212
(803) 407-0701

**Downtown-Columbia**
One Richland Medical Park, Suite 200
Columbia, SC 29203
(803) 929-0290

**Northeast**
3000 Northeast Medical Park, Suite 113
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(803) 788-8603