Welcome to our office. Enclosed, please find your registration materials.

PLEASE COMPLETE THIS PAPER WORK PRIOR TO YOUR ARRIVAL, OR REGISTER ON-LINE:

www.okemosallergycenter.com

IMPORTANT: PLEASE REVIEW THE MEDICATION INFORMATION SHEET. FAILURE TO READ THIS INFORMATION MAY CAUSE YOUR APPOINTMENT TO BE RESCHEDULED.

PLEASE BRING (OR PROVIDE A DETAILED LIST) OF ALL YOUR MEDICATIONS.

Allow 2 to 3 hours for this appointment.

We require payment of co-payments at the time of service. Allergy testing costs will vary depending on the number of items the patient is being tested for. If your insurance plan has a deductible, please be aware the cost of allergy testing may be applied to your deductible. We strongly suggest that you review your insurance plan and make note of any possible out-of-pocket costs. It is your responsibility to know your insurance plan and coverage details.

If you have any questions, please call our office. We look forward to your visit.

Regards,

Kamal Mohan, M.D.
Lawrence Hennessey, M.D.
Manoj Mohan, D.O.

TO OUR PATIENTS WHO ARE TO BE SKIN TESTED

Antihistamines and many other medications can interfere with allergy skin testing. Before your visit, please discontinue the following medications for the number of days indicated:

DO NOT STOP
TAKING YOUR
ASTHMA MEDICATIONS

ANTACIDS:
2 Days: Axid, Pepcid, Tagamet, Zantac, Tums Ultra

DO NOT NEED TO STOP:
Prevacid, Prilosec, Nexium

ANTI-ANXIETY/DEPRESSANTS:
1 Day: Limbitrol
3 Days: Elavil (prefer 7 days), Remeron
7 Days: Sinequan (Doxepin)
5 Days: Seroquel

ANTI-NAUSEA MEDICATIONS:
3 Days: Antivert, Compazine, Dramamine, Phenergan, Tigan

MUSCLE RELAXANTS:
5 *Days:* Flexeril

ANTI-HISTAMINES:
2 Days/Prescription: Allegra 60 mg, Allegra-D 12 Hour, Astelin Spray, Patanase Spray, Bromfed, Deconamine, Dimetane, Kronofed, Nolamine, Ornade, Rynatan, Ryna-S 12, Semprex, Trinalin, Fexofenadine 30 mg and 60 mg., Clemastine, Tavist II (Tavist I original formula).

2 Days/Over-the-Counter: Actifed, Benadryl, Brompheniramine, Chlor-Trimeton, Chlorpheniramine, Clemastine, Contac, Dimetapp, Diphenhydramine, Drixoral, Tavist, Excedrin PM

5 Days/Prescription: Allegra 180 mg., Atarax, Periactin, Vistaril (Hydroxyzine), Fexofenadine 180 mg., Allegra D 24 Hr., Xyzal, Cyproheptadine (Periactin)

5 Days/Over-the-Counter: All types of Claritin, Alavert, Loratadine., Zyrtec, Zyrtec D., Tavist Non-Drowsy Formula, Cetrizine.

6 Days/Prescription: Clarinex, Clarinex D.

There is no need to discontinue decongestants unless they are combined with antihistamines.

Please call our office if you have any questions about these or other medications.

ADULT PATIENT REGISTRATION FORM

(Please Print)

Personal Information

Check here if you have ever been seen by our office prior to today's appointment. ______

Name: ________________________________ Street Address: ________________________________

City: ________________________ State: _____ ZIP: _____________ Hm. Phone: ________________

Cell Phone: ________________________ Work Phone: ____________________________

Sex: _____ Marital Status: _____ Date of Birth: _______________________ Race: _____________________

Ethnicity: ___________________________

EMAIL ADDRESS: ____

Your Employer: ____

In Case of Emergency Notify:__________ ________________________________/______________________
(Name) (Phone)

Primary Care Physician: ______________________________________ Phone: ___________________

Preferred Pharmacy: __________________________________

Prescription Drug Plan: ________________________________

INSURANCE INFORMATION

(Please Present All Insurance Cards to Staff)

Primary Carrier: ____

Subscriber's Name: ______________________________________

Relationship to Patient: ______________________

Date of Birth: ________________________________

Billing Address (if other than patient's):
____

Contract No. ____________________________________ Group No. ________________________

Co-pay Amount (if any) $___________________

Employer Name: ____

Employer Address: ____

Phone: _________________

Secondary Carrier: ____

Subscriber's Name: _______________________________________

Relationship to Patient: _______________________

Date of Birth: ____________________________________

Billing Address (if other than patient's):
____

Contract No. _____________________________________ Group No. _________________________

Co-pay Amount (if any) $_________________

Employer Name: ____

Employer Address: ____

Phone: _________________

FINANCIAL POLICY

Thank you for allowing us to be part of your health care team. In order for us to provide the best possible care and to maximize your medical insurance policy coverage, you must provide accurate insurance information. This includes providing current insurance card(s) and informing our staff of any recent changes, including employment, coverage, or address.

The relationship you have with your insurance company and employer is a contract of which we are not part of. As a courtesy, our billing staff will process your claims for you, and answer any questions you may have. **Please be advised that, regardless of your insurance status, final responsibility for payment of our services is your obligation**.

It is the patient's responsibility to make sure proper prior authorizations and referrals are made and updated when needed.

Special Note for General Motors BCBS PPO Groups: Your plan will cover a portion of the Office Call. For Traditional Groups: Your plan does not cover Office Calls. **All other services, including skin testing, serums and injections, *are not covered by either plan***. If you have any questions, please speak with one of our Billing Specialists.

Co-payments are due at the time of service. A $5.00 Service Charge will be added if you do not pay your Co-Pay at Check-In.

We will make every attempt to notify you of your insurance coverage for our services, however, we cannot guarantee coverage for every service. Certain services, such as office calls, serums, injections, or testing may not be covered by your insurance.

I have read and understand the conditions set forth, and I authorize the treatment of my child and also the release of any medical or other information necessary to process the insurance claim(s). I also request payment of medical benefits be made directly to Okemos Allergy Center, P.C..

________________________________ ________________________________

(Responsible Party/Subscriber) **(Date)**

GUARANTEE OF PAYMENT FOR SERVICES

In the interest of providing you with uninterrupted quality medical care, we are advising you of the following:

There are some insurance companies that require an authorization before an office visit will be paid; others have their own insurance guidelines about when a visit to a specialist's office will be covered. ***It is your responsibility to know the extent of your insurance benefits and to get any required authorizations in advance of being seen. These authorizations must be in our office at the time of the visit.***

If, for any reason, your insurance company chooses not to cover your office visit or any procedures, you will be responsible for payment at the time of service. This includes all future visits. The estimated cost for a visit can be provided to you in advance.

Your signature below indicates that you will be responsible for payment in full should you fail to obtain an authorization, or should your insurance company choose not to pay for your visit.

I, {PATIENT.LABELNAME}, have read and agree with the above statement, and further agree to be responsible for all charges incurred, or to provide written approval authorization from my insurance company for all visits and procedures prior to being seen.

____
Patient Signature

Date: _____________________________

PATIENT HISTORY FORM

Please Answer Questions that Apply to You

Patient Name:

Date: _________________________

What are your symptoms? Mark an "X" after any of the following which apply to you. Mark "XX" if severe and "XXX" if extremely severe.

X		Onset Date	X		Onset Date
______	Coughing	_______	______	Nasal Blockage	_________
______	Sore Throat	_________	______	Wheezing	_________
______	Runny Nose	_________	______	Itchy Throat	_________
______	Shortness Breath	_________	______	Sneezing	_________
______	Headache	_________	______	Chest Pain	_________
______	Post Nasal Drainage	_________	______	Eye Itching	_________
______	Skin Itching	_________	______	Itchy Nose	_________
______	Tearing	_________	______	Skin Rash	_________
______	Nose Bleeds	_________	______	Ear Blockage	_________
______	Hives or Swelling	_________	______	Loss Taste/Smell	_________
______	Hearing Loss	_________	______	Nausea	_________
______	Diarrhea	_________	______	Indigestion	_________
______	Vomiting	_________	______	Colic/Cramps	_________
______	Hoarseness	_________	______	Frequent Colds	_________
______	Nervousness	_________	______	Fatigue	_________
______	Sinus Infections	_________	______	Insect Reactions	_________

Other: ____

____

2. Which symptom(s) is/are the most bothersome: ______________________________________

____

3. Do you have a history of any major diseases? ______Yes ______No If yes, please explain:

____

____

4. List hospitalizations:

Date:	Reason
______________________________	____
______________________________	____
______________________________	____
______________________________	____

5. Do your symptoms change with the seasons? ______Yes ______No If yes, which season(s) are worse:____

6. Do any of the following affect your symptoms:

When outdoors	Worse ______	Better ______	No Change ______
When indoors	Worse ______	Better ______	No Change ______
At night	Worse ______	Better ______	No Change ______
On exposure to house dust	Worse ______	Better ______	No Change ______
Sleeping on feather pillows	Worse ______	Better ______	No Change ______
On exposure to freshly cut grass	Worse ______	Better ______	No Change ______
In fields or tall weeds	Worse ______	Better ______	No Change ______
In barns, near hay, or raking leaves	Worse ______	Better ______	No Change ______
After exposure to animals	Worse ______	Better ______	No Change ______
On exposure to tobacco smoke	Worse ______	Better ______	No Change ______
On exposure to hair spray, perfume, or newsprint	Worse ______	Better ______	No Change ______
During or after exercise	Worse ______	Better ______	No Change ______

7. List foods that you suspect cause symptoms and describe the symptoms:

Food	Symptom(s)
______________________________	____
______________________________	____
______________________________	____
______________________________	____

8. List all drugs which cause symptoms:

Drug	Symptom(s)
______________________________	____
______________________________	____
______________________________	____
______________________________	____

9. Have you ever smoked? ______Yes ______No

   If yes, how much? ______________________________ Age Started ______ Age Stopped ______

10. What type of work do you do? (Please describe)

    ____

    ____

11. How do you feel at work when compared to home? ______Worse ______Better ______No Change

12. Have you had any lab work (blood tests, urine tests, etc.) or X-rays done recently?_____Yes _____No
    If yes, which tests were peformed? (Please bring in copies of the results if possible.)

    ____

    ____

13. What is your family history regarding allergies?

    ____

    ____

    ____

14. Please list current medications **INCLUDE MEDICATION NAME / STRENGTH / DOSE:**

    ____

    ____

    ____

    ____

15. Please list allergy medications that you have tried in the past, but did not work for you:

    ____

    ____

IN ORDER TO SHARE CHART/BILLING INFORMATION WITH ANY FAMILY MEMBERS (INCLUDING SPOUSES) YOU MUST PROVIDE PERMISSION. PLEASE COMPLETE THIS FORM

Limited Patient Authorization for Disclosure of Protected Health Information Form

Please print all information. Form must be signed and dated each year.

Patient Name: ____________________________

Date of Birth:______________________________

Purpose of request (who will be authorized to receive information) - I authorize Okemos Allergy Center

to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI)**:**

Name	Relationship to Patient
1. _______________________________	_________________________
2. _______________________________	_________________________
3._______________________________	_________________________

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:
☐ office notes
☐ nursing home, home health, hospice, and other physician records
☐ lab results, pathology reports
☐ record of HIV and communicable disease testing
☐ x-rays;
☐ Billing Information

* You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
* The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
* We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or representative signature:____ date: __________________