Dr Fame Allergy & Asthma

1002 Apperson Dr - Salem VA - 24153
Ph.(540) 404-9598 - Fax(540) 404-9608

Patient Information

First _____ MI_____ Last_____ __ Pt.ID #_____

Prefers to be called_____ Date of Birth ____/_____/_____ Age ____ Marital Status: _____
Married/ Single/Divorced/Widowed/Other

Address Primary _____ City _____ State_____ Zip _____

Alternate Address _____ City _____ State_____ Zip _____

Phone #1 _____ Phone #2 _____ Phone #3 _____
Home/Cell/ Work Home/Cell/ Work Home/Cell/ Work

Email address _____ Preferred method of contact: Letter Phone call Email Other_____

Sex____ SS # _____Referring Physician _____Primary Care Physician_____
M F

Preferred Language _____ Race: _____Ethnicity: _____
Non Hispanic or Latino/ Hispanic or Latino/ other or Undetermined

Referred by: Physician Self Family/Friend Internet Yellow pages Radio TV Other _____

Occupation_____Employer_____Is this visit related to a work injury? Y N

Current Pharmacy Name and Location _____

Emergency Contact

Name _____Phone # _____Relationship to patient_____

Responsible Party/Guardian/Guarantor Address Same as Patient ☐

Name_____ Address_____ _____ City_____ State ___ __Zip_____

Home# _____ Cell # _____ Business # _____

SS#_____ Patient's Relationship to Guarantor_____ DOB ____/____/____ ____

Sex _____ Occupation_____ Employer _____

Primary Insurance Information Address Same as Patient ☐

Name of Ins.Co. _____ ID # _____Group #_____Group Name_____

Policy Holder Name _____DOB ____/____/_____Relationship to Patient _____ _____

Address_____ ___ City_____ State_____ Zip_____ Phone #_____

SS# _____ Sex_____ Occupation_____ Employer _____

Secondary Insurance Information Address Same as Patient ☐

Name of Ins.Co. _____ID # _____Group# _____Group Name _____

Policy Holder Name _____ DOB ____/____/_____Relationship to Patient_____

Address_____City_____ State. _____Zip_____Phone# _____

SS# _____Sex_____Occupation_____Employer_____

List Any Persons to Whom You Will Allow Access of Your Medical Records

Name/Relationship_____ _____Name/Relationship_____

I hereby authorize the office of Fame Allergy PC to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payor to pay directly to Fame Allergy PC for services rendered. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

I acknowledge that I have received a copy of . Fame Allergy PC Notice regarding Privacy of Personal Health Information (PHI). I understand that .Fame Allergy PC may request a medication history from my pharmacy as part of my treatment plan, and I hereby give my consent for such requests.

Signature _____Signature_____ Date_____
Patient Responsible Party

Medical History Form

Name:_____ Date of Birth:_____

Past Medical History:
(check any of the following which you have now or have been treated for in the past)

☐ Alcoholism ☐ Anaphylaxis ☐ Cancer ☐ Celiac Disease
☐ Crohn's Disease ☐ COPD ☐ Diabetes ☐ Eczema
☐ Food Allergies ☐ GERD/Reflux ☐ Heart Disease ☐ Hives
☐ Hypertension ☐ Immunodeficiency ☐ Infections, recurring ☐ Immunotherapy, discontinued
☐ Prostate disorder ☐ Renal Calculus ☐ Snoring ☐ Substance abuse
☐ Thyroid problems ☐ Ulcerative colitis ☐ Venom Allergies Other_____
☐ Asthma ☐ Rhinitis (hay fever) _____

Surgical History:

☐ Adenoidectomy ☐ Appendectomy ☐ CABG (heart bypass)
☐ Gallbladder (Cholecystectomy) ☐ Colon Resection ☐ C- section
☐ Deviated Septum ☐ Ear tubes ☐ Hernia Repair
☐ Hip/knee Surgery ☐ Hysterectomy ☐ Organ Transplant
☐ Pacemaker ☐ Sinus Surgery ☐ Tonsillectomy & Adenoidectomy
☐ Tonsillectomy ☐ Thyroid Surgery Other_____

Family History (Immediate family only Mother, Father, Sibling or Children)

	Mother	Father	Sibling	Other
Allergies				
Anaphylaxis				
Angioedema				
Asthma				
Cystic Fibrosis				
Eczema				
Food Allergies				
Heart Disease				
Hives				
Hypertension (high blood pressure)				
Hyperlipidemia (high cholesterol)				
Immunodeficiency				
Infections, recurring				
Venom Allergies				
other _____				

Social History ***(13 years of age and older)***

marital status: ☐ single ☐ divorced/separated ☐ married ☐ widow(er)
smoking status: ☐ current every day smoker ☐ current some day smoker ☐ former smoker
☐ never smoker ☐ unknown if ever smoked
☐ cigarettes _____ packs per day ☐ cigars _____# per day ☐ smokeless/chew _____tins per day
smoking duration: ☐n/a ☐1-5 years ☐6-10 years ☐ 11-20 years ☐over 20 years year started: _____
maximum packs per day: ☐½ ☐1 ☐1 ½ ☐2 or more
passive cigarette exposure: ☐home ☐secondary ☐home ☐other ☐none
readiness to quit: ☐ very ready ☐ somewhat ready ☐ not ready ☐ relapsed ☐ not willing to quit target quit date:_____
occupation:_____ work location: ☐indoors ☐outdoor
caffeine intake (per day) ☐ 0 ☐ 1/2 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+
alcohol intake ☐ never ☐ rarely ☐ weekly ☐ daily ☐ socially
hobbies:_____

Pediatric patients only

attends ☐school ☐daycare (name of school/daycare) _____
does child have siblings ☐yes ☐no if yes, how many _____
child was born ☐premature ☐full term
delivery type ☐vaginal ☐C-section
complicated labor and delivery ☐yes ☐no
prolonged hospitalization as newborn ☐yes ☐no
breast fed ☐yes ☐no
feeding difficulties ☐yes ☐no
ABnormal growth and development ☐yes ☐no
LATE on immunizations ☐yes ☐no
severe infections ☐yes ☐no

Medications - Drug Allergies - Pharmacy

Name:_____ Date of Birth:_____

Current Medications and Supplements

(include milligram and number of times per day)

Medication Name	Strength	Times per Day	Taking This for What Diagnosis?

Allergies to Medications

Name of Medication	Reaction *(hives, throat swelling, other reactions)*

☐ **NO KNOWN DRUG ALLERGIES**

When was your last flu shot?_____

When was your last pneumonia shot?_____

Preferred Pharmacy:

_____(Name)
_____(Street Address)
_____(City, State, ZIP Code)
_____(Telephone Number)
_____(Fax Number)

Chief Complaint - Problem Review - Environment History

Name:_____ **Date of Birth:**_____

Reason for today's visit: _____

*Do you **CURRENTLY HAVE ONGOING /RECURRING PROBLEMS** with any of the following:*

General	Nose	Gastrointestinal	Neurologic
☐ no problem	☐ no problem	☐ no problem	☐ no problem
☐ failure to thrive	☐ nasal congestion	☐ heartburn	☐ headaches
☐ fever	☐ runny nose	☐ nausea	☐ weakness
☐ chills	☐ post nasal drip	☐ vomiting	☐ seizures
☐ sweats	☐ nose bleed	☐ diarrhea	☐ passing out
☐ poor appetite	☐ itching	☐ constipation	☐ dizziness
☐ fatigue	☐ sneezing	☐ abdominal pain	
☐ malaise		☐ bloody stool	**Mental Health**
☐ weight loss	**Throat**	☐ jaundice	☐ no problem
	☐ no problem		☐ depression
Eyes	☐ hoarseness	**Musculoskeletal**	☐ anxiety
☐ no problem	☐ difficulty swallowing	☐ no problem	☐ hyperactivity problem
☐ blurring	☐ sore throat	☐ back pain	☐ behavior problems
☐ discharge	☐ oral ulcers	☐ joint pain	
☐ eye pain	☐ throat clearing	☐ joint swelling	**Allergic /Immunologic**
☐ itchy	☐ itching	☐ stiffness	☐ no problem
☐ red			☐ recurring infections
☐ vision loss	**Cardiovascular**	**Skin**	☐ bee sting reaction
☐ watery	☐ no problem	☐ no problem	☐ food reaction
	☐ chest pains	☐ angioedema	☐ latex reaction
Ears	☐ palpitations	☐ dryness	
☐ no problem	☐ passing out	☐ hives	
☐ earache	☐ leg swelling	☐ itching	
☐ ear discharge	☐ shortness of breath lying down	☐ rash	
☐ ringing in ears			
☐ decreased hearing	**Respiratory**		
☐ ears popping	☐ no problem		
☐ room spinning around	☐ cough		
☐ itching	☐ chest tightness		
	☐ coughing up blood		
	☐ daytime sleepiness		
	☐ shortness of breath		
	☐ snoring		
	☐wheezing		

Housing	Foundation	Air Conditioning	Heating
☐ house	☐ basement	☐ none	☐ none
☐ apartment/condo	☐ crawlspace	☐ window units	☐ wood stove
☐ mobile/ manufactured home	☐ slab	☐ central	☐ central hot air
		☐ evaporative cooler	☐ kerosene
			☐ electric space heater
			☐ natural gas

Indoor Mold	Water Damage	Pests	Smoke Exposure	Bedroom
☐ none	☐ none	☐ none	☐ none	☐ carpet
☐ AC vents	☐ leaky roof	☐ roaches	☐ parents	☐ ceiling fan
☐ bathroom	☐ plumbing problems	☐ rodents	☐ spouse/partner	☐ humidifier
☐ window frames	☐ musty odors		☐ grandparent	☐ sleeps in own bed
☐ walls	☐condensation		☐ caretaker	☐ shares bed
☐ basement	☐ water stains		☐ other _____	

Bed	Outdoor Environment	Pets	(how many)
☐ crib mattress	☐ none	☐ none	Dog Inside: _____
☐ standard mattress	☐ cattle	☐ dogs	Dog Outside:_____
☐ water bed	☐ chickens	☐ cats	Cat Inside: _____
☐ down pillow/ comforter	☐ horses	☐ birds	Cat Outside:_____
☐ dust ruffle	☐ goats	☐ hamsters	
☐ stuffed toys	☐ farm	☐ gerbils	
☐ wool blanket		☐ rabbits	
☐ allergy pillow cover		☐ guinea pigs	
☐ allergy mattress cover		☐ other_____	
☐ pets sleeps in bed			

Fame Allergy P.C.
1002 Apperson Drive, Salem, VA 24153

Phone – 540-404-9598
Fax – 540-404-9608

NOTICE OF INFORMATION PRACTICES

1. Fame Allergy P.C. may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

2. Fame Allergy P.C. is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health uses or court orders.

3. An authorization from the patient is required for uses or disclosures for marketing purposes and for any disclosure constituting the sale of protected health information. No other use or disclosure of a patient's protected health information will be made without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. Patients have the right to opt out of any communication involving fundraising. In the event of a breach of unsecured protected health information, a notification will be provided. Fame Allergy P.C. will abide by the terms of the notice currently in effect at the time of the disclosure.

5. Fame Allergy P.C. reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Fame Allergy P.C. will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes. Additionally, any patient, guardian or personal representative has the right to inspect and obtain their medical record, as well as request amendments be made to their medical record.

7. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.

8. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket; but if the Practice does agree, the Practice must abide by those restrictions.

9. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the address and/or phone number listed above. All complaints will be addressed and the results will be reported to the Privacy Officer.

10. It is the policy of Fame Allergy P.C. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Effective date: _____ Name of Patient: _____

Signature of Patient or Legal Guardian: _____ Date: _____

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CONSENT FORM
(For Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (TPO)

I understand that as part of my healthcare, Fame Allergy P.C. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many 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
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **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 the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested other than the exception noted in the **Notice of Information Practices**. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, Fame Allergy P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Fame Allergy P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Fame Allergy P.C. may e-mail to me appointment reminders and patient statements. I have the right to request that Fame Allergy P.C. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket, but if it does, it is bound by this agreement.

By signing this form, I am consenting for Fame Allergy P.C. to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Fame Allergy P.C. may decline to provide treatment to me.**

Print Patient Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

FAME ALLERGY P.C.

PAYMENT POLICY

Fame Allergy P.C. strives to ensure a clear understanding to your financial responsibility with respect to the medical services we provide. These policies apply to all procedures.

1. Co-Pays: We require payment of co-pays at the time of service.

2. No Insurance: If you have no insurance, **we collect** $250 for your initial office visit, and $75 for a follow-up appointment **at the time of your visit.**

3. Payments: We accept cash, checks, money order and all major credit/debit cards.

4. Insurance Coverage: We will file your claim with your insurance company as a courtesy. We do not enter into disputes over insurance benefits or coverage. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement, or we are a participating provider. Please keep in mind that payment remains your responsibility. You agree to pay any portion of the charges not covered by insurance.

5. Broken Appointments: All broken appointments that are not cancelled within 24 hours advanced notice may receive a no-show fee of $60 for new patient and $35 for follow up appointments.

6. Delinquent Accounts:

A. Late Payment Fees. In the event that an outstanding payment is not made when the sum becomes due and payable, the entire amount may become due and payable at once, without notice at the option of Fame Allergy P.C. In that event, Fame Allergy P.C. shall be entitled to interest, at thirteen percent (13%) annually for the outstanding balance, starting from the date of default.

B. Account Termination. If an account is delinquent 150 days, Fame Allergy P.C. will send the account to a collection agency. At that time, the patient will be unable to receive services until the account and all fees are paid in full.

C. Collection. Once this obligation has become delinquent 150 days, it will be placed in the hands of a collection agency. In this event, the responsible party agrees to pay the balance due, as well as any court costs, collection fees, or attorney fees for the amount remaining unpaid.

D. Waiver, Venue; Choice of Law. The patient and all endorsers, sureties, and guarantors hereby severally waive the benefit of the Homestead Act and all other exemptions as to this obligation. The parties agree that Virginia law governs this Agreement. Should any dispute arise from this Agreement, the parties agree to adjudicate the matter at the Roanoke City Court.

IT IS AGREED THAT A SIGNED COPY OF THIS STATEMENT/AGREEMENT WILL BE RETURNED TO OUR OFFICE BEFORE ACTIVE TREATMENT BEGINS

I/we hereby certify that I/we have read and/or received a copy of the foregoing Payment Policy

Effective **Date**: _____ Name of **Patient**: _____

Signature of Patient,
Legal Guardian, and/or Responsible Party: _____