The Center for Allergy & Immunology
Kansas City Physician Partners

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Avoiding antihistamines in preparation for skin testing:

Allergy skin testing is often used to help determine environmental, food or drug allergies. Many skin prick tests are often placed during a new visit. If you believe you will be undergoing skin prick testing for allergies please remain off medications such as antihistamines for at least 5-7 days prior to testing. It is safe to continue taking Singulair, asthma inhalers, and steroid nose sprays as they will not interfere with skin testing.

Number of days required to be off of medication:

Seven days:
Actifed (triprolidine HCL)
Alavert (loratadine)
Allegra (fexofenadine)
Atarax (hydroxyzine)
Benadryl (diphenhydramine)
Chlor-Trimeton (chlorpheniramine)
Clarinex (desloratadine)
Claritin (loratadine)
Contac (phenylpropanolamine)
Dimetapp (brompheniramine)
Dristan (chlorpheniramine)
Sinutab (chlorpheniramine)
Tavist (clemastine)
Vistaril (hydroxyzine)
Xyzal (levocetirizine)
Zyrtec (cetirizine)

Three Days:
Astelin (azelastine) – nose spray
Astepro (azelastine) – nose spray
Dymista (fluticasone / azelastine) – nose spray
Patanase (olopatadine) – nose spray

Two Days: H2-blockers for GERD
Zantac (ranitidine)
Tagamet (cimetidine)
Pepcid (famotidine)

One Day: Allergy eye drops
Optivar
Patanol
Pataday
Pazeo
Elestat
Bepreeve
Lastacaft
Zaditor (ketotifen)

Medicines okay to use and will not interfere with skin testing: Singulair (montelukast), any type of asthma inhaler, nasal steroids (Flonase, Veramyst, Nasonex, Nasacort, Rhinocort, etc…)

Please note, if you are coming for chronic hives of unexplained cause and require antihistamines to be free of hives and have an acceptable quality of life, do not come off your antihistamines.

Allergy, Asthma, and Immunology New Patient Questionnaire

INSTRUCTIONS: Please complete as carefully as possible. Bring it with you at the time of your appointment. All information will be considered confidential.

NAME _____ PRIMARY PHYSICIAN _____

DOB _____ AGE_____ PRIMARY PHYSICIAN ADDRESS_____

ADDRESS _____ _____

_____ _____

TELEPHONE _____

EMAIL:_____

HOW DID YOU HEAR ABOUT US?

- □ Doctor (Name:_____)
- □ Web search
- □ Friend/family
- □ Insurance listing
- □ Advertisement

PHARMACY:_____

Pharmacy Address_____

_____

Please describe the reason for your visit and what you hope to accomplish.

_____

_____

_____

_____

_____

_____

Review of Systems: Please circle any of the below symptoms that you are currently experiencing. Leave blank if you are not having any symptoms in that area:

□ Eyes:	Pain	Swelling	Blurry vision	Double vision	Dry eyes
□ Ears:	Pain	Ringing	Hearing loss		
□ Nose:	Sneezing	Congestion	Sinus pressure	Loss of smell	Runny nose
□ Respiratory:	Shortness of breath	Cough	Wheezing	Chest tightness	
□ Cardiovascular:	Racing heart	Must sleep sitting up			
□ GI:	Heartburn	Stomach pain	Nausea	Vomiting	Trouble swallowing
□ Musculoskeletal:	Joint pain	Muscle ache	Muscle weakness		
□ Neurologic:	Dizziness	Headache			
□ Psychiatric:	Anxiety	Difficulty concentrating	Irritability		
□ Constitutional:	Fevers	Unintentional weight loss	Chills	Weight gain	Fatigue / malaise
□ Skin:	Dryness	Dry hair	Itching	Rash	

History of Present Illnesses: The next several pages ask you to fill in details about the problems that bring you to our allergy and immunology clinic. We know it is a lot of information! By filling these out prior to your visit, we can get a lot of the "housekeeping work" out of the way and be able to focus a lot more on your specific questions and concerns in our allotted time. Please note, if you are not coming in for that problem (nasal allergies, asthma, chronic cough, stinging insect allergy, food allergy, drug allergy, hives/swelling, eczema, recurrent infections, etc…) please leave those sections blank.

Have you ever had any of the following problems? If not, leave blank.

Yes	No	Problems	Age of Onset	Comments
		Nasal Allergies (sniffling, sneezing, runny nose, stuffy)		
		Sinus Problems		
		Asthma / Wheezing		
		Food Allergy		
		Chronic hives and/or swelling		
		Chronic cough		
		Drug Allergy		
		Any other breathing problems		
		Eczema or other rashes		
		Latex Allergy		
		Vaccine Allergy		
		Stinging insect allergy		
		Frequent infections / immune deficiency		

Do you have any of the following symptoms on a regular basis? If not, leave blank.

	Severity		
	Mild	Moderate	Severe
Sneezing			
Itchy nose			
Runny nose			
Dripping sensation in back of throat			
Throat Clearing			
Nasal Congestion			
Ear pain / popping / fullness			
Red eyes			
Itchy eyes			
Watery eyes			
Headaches			
Sinus pain or pressure			
Discolored nasal drainage			
Decreased sense of smell			
Snoring			
Mouth breathing			
Nighttime pauses in breathing			
Waking up at night choking or gasping for air			

Within the past month, how did the following affect you?
0 = No problem 5 = Severe problem

	0	1	2	3	4	5
Hoarseness or a problem with your voice?						
Clearing your throat?						
Excess throat mucus or postnasal drip						
Difficulty swallowing food, liquids or pills?						
Coughing after you ate or lie down						
Breathing difficulties or choking episodes?						
Troublesome or annoying cough?						
Sensations of something sticking in your throat or a lump in your throat?						
Heartburn, chest pain, indigestion, or stomach acid coming up?						

RSI Score (MD Use): _____

If you have asthma, have you ever been:

Hospitalized for asthma?	Yes	No	If yes, in the past year, how many times_____?
Treated in the Emergency Room for asthma?	Yes	No	If yes, in the past year, how many times_____?
Treated with oral steroids for an asthma attack?	Yes	No	If yes, in the past year, how many times_____?

Do you have a written asthma action in place? _____Yes _____No

How many asthma attacks do you estimate you have had in your lifetime? _____ In the last year? _____

Please complete if you have asthma and are **over** twelve years of age, circle the answer:

In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home?				
All of the time	Most of the time	Some of the time	A little of the time	None of the time
During the past 4 weeks, how often have you had shortness of breath?				
More than once per day	Once a day	3 to 6 times per week	Once or twice a week	Not at all
During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain), wake you up at night or earlier than usual in the morning?				
4 or more nights per week	2 or 3 nights per week	Once a week	Once or twice a week	Not at all
During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?				
3 or more times per day	1 or 2 times per day	2 or 3 times per day	Once a week or less	Not at all
How would you rate your asthma control during the past 4 weeks?				
Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completely controlled

ACT Score (MD use): _____

Please circle what asthma symptoms you experience:

- Wheezing
- Trouble breathing
- Trouble getting air in
- Trouble getting air out
- Coughing
- Exercise intolerance
- Symptoms in middle of night

Please check any factors that seem to trigger your allergy and/or asthma symptoms:

- Pollens
- Raking leaves
- Cut grass
- Dust
- Mold
- Cat
- Dog
- Other animals
- Exercise
- Changes in weather
- Air conditioning
- Strong odors
- Forced air heat
- Wood burning
- Tobacco smoke
- Cleaning agents
- Scented candles
- Perfumes / colognes
- Alcohol
- Menstruation
- Dried fruits
- Stress
- Spicy foods
- Exposures at work (e.g. chemicals, paints, flour): Specify_____

Are the symptoms present (circle all that apply): Throughout the year During certain seasons
What seasons or months are they worse? _____

Have you missed time from school or work because of your allergies or asthma? _____ If so, how many days? _____

Have you had allergy testing? □ Yes □ No If yes, date(s): _____ Physician's name:_____
Results of the tests (if possible, please provide us with a copy):

_____

_____

Have you ever received allergy injections? □ Yes □ No Were they of any benefit? □ Yes □ No
Prescribing Physician: _____

To the best of your ability, please fill out the table below for medications you have tried for your nasal allergies and/or asthma:

Medication	Dose	Frequency	Taking now	Taken in past	How long did you try it?	No help	Helped a little bit	Helped a moderate amount	Completely relieved symptoms	Side Effects
Antihistamines										
Benadryl										
Zyrtec										
Allegra										
Claritin										
Clarinex										
Xyzal										
Nasal sprays										
Flonase										
Nasonex										
Nasacort										
Dymista										
Rhinocort										
Astelin										
Astepro										
Patanase										
Saline wash										
QNasl										
Zetonna										
Asthma meds										
Prednisone 5-day										
Prednisone daily										
Singulair										
Advair										
Dulera										
Symbicort										
Breo Ellipta										
Pulmicort										
Flovent										
Asmanex										
Aerospan										
Qvar										
Avesco										
Xolair										
Nucala										
Albuterol										
Levalbuterol										

If you are coming in for evaluation of a cough, please complete the following questions:

1. How long has the cough been present: _____days _____weeks _____months _____years

2. How would you describe the cough?
   - ☐ Dry, hacking
   - ☐ Wet, productive
   - ☐ Tickle in the throat
   - ☐ Coughing with wheezing

3. Check if any of this applies to you:
   - ☐ Vomiting after the cough
   - ☐ History of recurrent respiratory tract infections
   - ☐ History of reflux disease
   - ☐ Waking up at night with the cough
   - ☐ Cough worse when laying down
   - ☐ Takes lisinopril, enalapril, captopril for blood pressure
   - ☐ History of asthma
   - ☐ Smoker

4. Check if you have had any of the following performed for evaluation of the cough:
   - ☐ Pulmonary function testing
   - ☐ Chest X-ray
   - ☐ Chest CT scan
   - ☐ Sinus CT scan
   - ☐ Allergy testing
   - ☐ Swallow study
   - ☐ Bronchoscopy
   - ☐ EGD
   - ☐ Exhaled nitric oxide

5. Have you tried any of the following treatments?

Medication class	**Check if yes**	**How long did you try it?**	**Effectiveness**			**Side Effects**
			Helped a little bit	Helped a moderate amount	Completely relieved symptoms	
Oral steroids						
Inhaled steroids						
Nasal steroids						
Antihistamines						
Decongestants						
Cough suppressants						
Antibiotics						
Albuterol						
Reflux medications						
Gabapentin						
Amitriptyline						

Have you been stung before by an insect and had an allergic reaction? _____Yes _____No

If so, do you know what stung you?
- ☐ Honey bee
- ☐ Yellow jacket
- ☐ Wasp
- ☐ Hornet
- ☐ Fire ant
- ☐ Don't know

What were your symptoms?
- ☐ Local reaction only around the sting site
- ☐ Hives everywhere / flushed and itchy
- ☐ Wheezing / breathing problems
- ☐ Swelling of lips / tongue / eyes
- ☐ Lightheadedness / passing out
- ☐ Abdominal cramping vomiting

What was the timing between the sting and the symptoms starting?
- ☐ Less than 15 minutes
- ☐ Less than 30 minutes
- ☐ Less than 1 hour
- ☐ 1-6 hours hours
- ☐ Over 12 hours

How were the symptoms treated?
- ☐ Oral antihistamines
- ☐ Oral steroids
- ☐ Epinephrine injection
- ☐ IV steroids
- ☐ IV antihistamines
- ☐ IV epinephrine drip

Environmental History:

1. What city or town do you live in?:_____
2. Do you live in a house, apartment, or townhouse / condo?: _____
3. Approximately how old is the living space?: _____
4. Has there been any water damage in your home?: _____
5. Do you have problems with mold / water damage? _____
6. Type of air conditioning (circle): Central Window unit None
7. How often are the air conditioning filters changed?: _____
8. Do you have a basement?: _____
9. Is your living room carpeted? _____
10. Is your bedroom carpeted? _____
11. Does anyone smoke around the environment (inside or outside)? _____
12. Do you have any pets? If so, what type and how many? _____
13. Are there pets allowed in the bedroom? If so, do they sleep there? _____

SINO-NASAL OUTCOME TEST (SNOT-20)

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks.

Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale:

		0	1	2	3	4	5
1	Need to blow nose						
2	Sneezing						
3	Runny nose						
4	Cough						
5	Post-nasal discharge						
6	Thick nasal discharge						
7	Ear fullness						
8	Dizziness						
9	Ear pain						
10	Facial pain/pressure						
11	Difficulty falling asleep						
12	Wake up at night						
13	Lack of a good night's sleep						
14	Wake up tired						
15	Fatigue						
16	Reduced productivity						
17	Reduced concentration						
18	Frustrated/restless/irritable						
19	Sad						
20	Embarrassed						

0 = no problem
1 = very mild problem
2 = mild or slight problem
3 = moderate problem
4 = severe problem
5 = problem is as bad as it can be

Scoring:
0-10: No problem to mild problem
11-40: Moderate problem
41-69: Moderate to severe
70-100: Severe to "as bad as it can be"

Score:_____

Please fill this out if the patient has asthma and is between 4-12 years of age.

SCORE

1. How is your asthma today?

0	1	2	3
Very bad	Bad	Good	Very good

2. How much of a problem is your asthma when you run, exercise or play sports?

0	1	2	3
It's a big problem, I can't do what I want to do.	It's a problem and I don't like it.	It's a little problem but it's okay.	It's not a problem.

3. Do you cough because of your asthma?

0	1	2	3
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.

4. Do you wake up during the night because of your asthma?

0	1	2	3
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.

Please complete the following questions on your own.

5. During the last 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?

5	4	3	2	1	0
Not at all	1-3 days/mo	4-10 days/mo	11-18 days/mo	19-24 days/mo	Everyday

6. During the last 4 weeks, on average, how many days per month did your child wheeze during the day because of asthma?

5	4	3	2	1	0
Not at all	1-3 days/mo	4-10 days/mo	11-18 days/mo	19-24 days/mo	Everyday

7. During the last 4 weeks, on average, how many days per month did your child wake up during the night because of asthma?

5	4	3	2	1	0
Not at all	1-3 days/mo	4-10 days/mo	11-18 days/mo	19-24 days/mo	Everyday

If you have problems with hives and/or swelling of unexplained cause, please answer the following questions:

1. How long have the hives been present: _____days _____weeks _____months _____years

2. Where do the hives occur?
   - ☐ Everywhere
   - ☐ Arms
   - ☐ Legs
   - ☐ Palms/soles
   - ☐ Face
   - ☐ Trunk

3. Check any of the following to describe the hives:
   - ☐ Itchy
   - ☐ Painful
   - ☐ Burning
   - ☐ Red
   - ☐ Raised
   - ☐ Leave bruising
   - ☐ Fluid-filled blisters
   - ☐ Ring-like with central clearing

4. Do you have swelling with the hives? _____Yes _____No

5. If so, where does the swelling occur:
   - ☐ Lips
   - ☐ Around eyes
   - ☐ Tongue
   - ☐ Facial
   - ☐ Throat
   - ☐ Fingers
   - ☐ Other:_____

6. How frequently do the hives occur?
   - ☐ Daily
   - ☐ 5-7 times per week
   - ☐ 3-5 times per week
   - ☐ 1-3 times per week
   - ☐ 2-4 times per month
   - ☐ < 2 times per month

7. How long does each bout of hives last
   - ☐ Under 4 hours
   - ☐ 4-8 hours
   - ☐ 8-12 hours
   - ☐ 12-24 hours
   - ☐ 1-2 days
   - ☐ Over 2 days

8. Check the following treatments you have used for the hives
   - ☐ As needed antihistamines
   - ☐ Preventative antihistamines – normal dose
   - ☐ Preventative antihistamines – double dose
   - ☐ Preventative antihistamines – triple dose
   - ☐ Preventative antihistamines – quadruple dose
   - ☐ Singulair (montelukast)
   - ☐ Zantac (ranitidine)
   - ☐ Steroid bursts (short-term)
   - ☐ Chronic daily steroids
   - ☐ Doxepin
   - ☐ Xolair (omalizumab)
   - ☐ Other: _____

9. Check if any of the following applies to you:
   - ☐ Regular use of NSAIDs (ibuprofen, naproxen, aspirin)
   - ☐ ACE inhibitor use in the past 3-4 months
   - ☐ International travel
   - ☐ Well water

Please fill out the following tables if the patient is between 6-24 months of age:

	Yes	**No**
Any eczema prior to age 3 months -10 points		
Severe eczema beginning after 3 months - 7 points		
Any eczema - 5 points		
History of food allergy - 7 points		
Any wheezing illness - 3 points		
Sibling or parent with food allergy - 3 points		
Family history of atopy but not food allergy - 2 points		

Introduced into diet without problem	**Yes**	**No**
Peanut products		
Soy		
Egg		
Milk products		
Wheat		
Tree nut products		
Fish		
Shellfish		

Have you had reactions to foods? If so please describe the reaction below:

Food	Age of Onset	Symptoms	Time span from ingestion to symptoms	Date of last reaction	Date last food eaten

For your allergic reactions to foods, how have allergic reactions been treated in the past? Check all that apply.

- ☐ Oral antihistamines
- ☐ Oral steroids
- ☐ Epinephrine injection
- ☐ Oral steroids
- ☐ IV steroids
- ☐ IV antihistamines
- ☐ IV epinephrine drip

Have you had positive allergy testing to the foods before? _____Yes _____No

Do you have a written food allergy action in place? _____Yes _____No

Please answer the following questions if you have eczema or atopic dermatitis:

1. How long has it been present: _____weeks _____months _____years

2. Describe the rash:
   - ☐ Red
   - ☐ Itchy
   - ☐ Painful
   - ☐ Irritated
   - ☐ Dry
   - ☐ Blistering
   - ☐ Golden crusting
   - ☐ Oozing / weeping

3. Where is the rash located?
   - ☐ Everywhere
   - ☐ Behind knees
   - ☐ Elbows
   - ☐ Face
   - ☐ Trunk
   - ☐ Back
   - ☐ Legs
   - ☐ Arms

4. What is your moisturizer? _____

5. How often do you apply it?_____

6. What is your bath/shower soap? _____

7. What is your laundry detergent? _____

8. What treatments have you used for the rash?

Medication	**Dose**	**Frequency**	**How long did you try it?**	**Effectiveness**			Side Effects
				Helped a little bit	Helped a moderate amount	Completely relieved symptoms	

Please answer the following questions if you are coming in for evaluation of recurrent infections or immune deficiency:

1. How long have the recurring infections been present?_____

2. How many courses of antibiotics have you had in the past twelve months? _____

3. What type of infections do you have (check all that apply):
   - ☐ Sinus infections
   - ☐ Upper respiratory tract infections
   - ☐ Fungal infections of the skin or nail
   - ☐ Fungal infections of the lung
   - ☐ Pneumonia
   - ☐ Skin infections
   - ☐ Atypical or opportunistic infections (_____)
   - ☐ Bronchitis
   - ☐ Gastrointestinal infections

4. Please check if you have had any of the following:
   - ☐ Sepsis
   - ☐ Osteomyelitis (infected bone)
   - ☐ Sinus surgery
   - ☐ Bacteremia
   - ☐ IV antibiotics (other than before surgery)
   - ☐ Chest tube
   - ☐ Meningitis
   - ☐ Overnight stay in hospital for infection

5. Have you had immunology testing done before? _____Yes _____No

6. Are you currently being treated with supplemental immunoglobulin? _____Yes _____No

   a. Who is the prescriber? _____

   b. What is the brand?_____

   c. What is the route? _____Intravenous (IV) _____Subcutaneous (SC)

   d. Do you have any problems with the infusion? _____Yes _____No

   e. How frequently are labs drawn? _____

   f. Are you able to get copies of the labs that were performed that showed you needed immunoglobulin? ____Yes ____No

Please list your current non-allergy medications and dose, including over-the-counter medications and vitamin or herbal supplements:

Name	Dose	Times per Day	How long	Reason

Are you allergic to any medications? If so, please fill out the below table:

If none known, check here □

Medications	Age of Onset	How many doses until symptoms?	Symptoms (please check all that apply)		Time span from initiation to symptoms
			□ GI upset □ Hives all over □ Just a few hives □ Coughing □ Wheezing / problems breathing □ Swelling of lips / tongue / eyes □ Just a few hives	□ Rash (mostly little asymptomatic bumps) □ Blistering of skin □ Blistering of mouth □ Bulls-eye rash □ Eczema type rash □ Other:	□ ___hours □ ___days □ ___weeks □ ___months
			□ GI upset □ Hives all over □ Just a few hives □ Coughing □ Wheezing / problems breathing □ Swelling of lips / tongue / eyes □ Just a few hives	□ Rash (mostly little asymptomatic bumps) □ Blistering of skin □ Blistering of mouth □ Bulls-eye rash □ Eczema type rash □ Other:	□ ___hours □ ___days □ ___weeks □ ___months

Past Medical History:

Please check if you have ever experienced any of the following:

- ☐ Recurrent ear infections / ear tubes
- ☐ Glaucoma
- ☐ Thyroid disease
- ☐ Migraines
- ☐ Seizures
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Nasal polyps
- ☐ Cancer (please specify below)
- ☐ GERD / heartburn
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Hepatitis (write type)
- ☐ Bronchiectasis (a type of scarring of the lung)
- ☐ Speech delay
- ☐ Diabetes
- ☐ Elevated cholesterol
- ☐ Osteoporosis
- ☐ Premature birth / NICU stay
- ☐ Poor growth on growth curve
- ☐ Any severe infections (please write them)

Do you have any other medical problems? If so please list them:

_____

_____

Have you ever had any of the following surgeries? Please check all that apply and write the approximate year next to the item:

- □ Sinus surgery
- □ Nasal or sinus polypectomy
- □ Nasal septum correction
- □ Turbinate reduction surgery
- □ Ear tubes / myringotomy tubes
- □ Tonsillectomy
- □ Adenoidectomy
- □ Chest tube placement for pneumonia

Any other surgeries?_____

Family History: If adopted and not known, check here □

Disease	Yes	No	Mother	Father	Sister	Brother	Son	Daughter
Asthma								
Nasal allergy symptoms								
Eczema / atopic dermatitis								
Food Allergies								
Hives								
Hereditary angioedema								
Thyroid disease								
Immune Deficiency								
Autoimmunity (Lupus, RA)								
Leukemia / Lymphoma								

Social History for adult patients:

1. Have you ever smoked cigarettes? _____
2. How old were you when you started? _____
3. If you have quit, how old were you when you quit smoking? _____
4. How many packs per day did you (do you) average? _____
5. Do you drink alcohol (if yes, how many drinks per week)? _____
6. What is your occupation? _____
7. Do you believe your occupation has any bearing on your illness, please explain_____
   _____
8. Are you married? If so, what is your spouse's first name and occupation? _____
9. Do you have children? What are their ages? _____
10. Do any of your other family members go to this clinic? _____

Social History for pediatric patients:

1. Who lives in the house? (parents, siblings, grandparents, etc…):_____
2. What grade is the patient in? (if applicable) _____
3. What is the patient's favorite subject in school? _____
4. What are the patient's hobbies (sports or what they do for fun)? _____
5. Is the patient in daycare / preschool? If yes, approximately how big is their class size? _____
6. What are the parents (or guardians) first names and occupations? _____

YOU HAVE NOW SUCCESSFULLY COMPLETED THE NEW PATIENT PAPERWORK.

THE FOLLOWING FORMS DETAIL OUR HIPAA AND FINANCIAL POLICIES AND ALSO INCLUDE OUR MEDICAL RECORDS RELEASE FORM IF NEEDED.

YOU CAN FILL THEM OUT NOW TO HOPEFULLY GET BACK TO THE EXAM ROOM QUICKER UPON YOUR ARRIVAL.

IF YOU HAVE ANY QUESTIONS REGARDING THE FORMS, YOU CAN LEAVE THE FORM BLANK AND GET MORE INFO FROM OUR FRONT DESK WHEN YOU ARRIVE. THANK YOU!

HIPAA

"I_____" have been presented with an updated copy of the Kansas City Physician Partners Notice of Privacy Practices revised per HIPAA Omnibus Rule.

_____ _____

PATIENT SIGNATURE **DATE**

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes: *Information needed for continuation of medical care.*

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by: ***Kansas City Physician Partners, Inc (KCPP) The Center for Rheumatic and Allergy Disease and Immunology – Physicians and Staff***

Persons to Whom Information May be Disclosed
Information described above may be disclosed to:

_____ **I** authorize KCPP to leave a message on my answering machine at home or cell phone regarding any test results, treatment recommendations and/or diagnosis information.

_____ I authorize KCPP to leave a message on my answering machine at my work phone regarding any test results, treatment recommendation and/or diagnosis information.

_____ I authorize KCPP to mail a reminder card to my home regarding any future appointments with this office.

Please list any persons who are authorized to be present during your examination and/or receive information regarding your medical treatment, diagnosis, and treatment recommendations provided by this office and appointment information.

_____

Name of person or organization:

_____

Name of additional persons or organization

Expiration Date of Authorization
This authorization is effective for five years unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Kansas City Physician Partners (KCPP)/ The Center for Rheumatic Disease and Allergy Immunology. You should contact either the Clinical or Practice Manager to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations

_____ _____

Print/Type Name of Patient **Signature of Patient**

_____ _____

Signature of Patient Representative **Date**

Kansas City Physician Partners, Inc.
The Center for Rheumatic Disease
The Center for Allergy & Immunology
The Medical Plaza II, 4330 Wornall Rd. Ste 40 Kansas City, MO 64111
Telephone: 816-531-0930 Fax: 816-753-2671
www.kcphysicianpartners.com

Authorization for Release of Medical Information

I hereby authorize _____

_____

_____

Phone/Fax: _____

To Release to: _____
Kansas City Physician Partners, Inc.
The Center for Rheumatic Disease and
The Center for Allergy & Immunology

NAME: _____ DOB: _____

ADDRESS: _____

Primary Contact Phone Number(s): _____

_____ _____
Patient / Legal Guardian Signature Date

_____ _____
Legal Guardian / Representative Date

_____ _____
Physician Signature Date

Kansas City Physician Partners Financial Policy

Updated October 29, 2015

Thank you for choosing Kansas City Physician Partners (KCPP) for your healthcare needs. We are honored by your choice. We strive for effective communication and we wish to inform you of our policies as they pertain to payment for services rendered. Please review this document and then sign to acknowledge your understanding of our financial policies. Should you have any questions, our office staff will be pleased to help you. We value our relationship with you and pledge to serve you with the highest quality of care.

Patient Information

All KCPP patients complete patient registration forms on an annual basis. Your photograph *may* be taken to ensure identity and reduce the risk for identity theft.

Insurance Plans

If you have an insurance plan for which we are a participating provider, we will submit your claims as per our agreement with your insurance company. Although we may be a participating provider with your insurance company, there are still times when claims are denied by your insurance company. For concerns regarding any coverage issues, please contact your insurance company for verification.

It is extremely important that we have the correct insurance information at each and every visit. Failure to notify us of any changes within 30 days of your visit may result in a denial of your insurance claim, at which time, charges become your responsibility.

If you have an insurance plan for which we are not a participating provider, you will be responsible for full payment of all charges you have incurred at the time of service. You will be given copies of the charges, so that you may submit them to your insurance company for reimbursement.

Insurance Claims

Primary Insurance: Submission of claims to your insurance company is dependent upon your submission of proof of insurance (i.e. your insurance card) to us. In the event you have insurance coverage but cannot provide documentation, payment is due at the time of service. If provided within 30 days of the visit, upon receiving your insurance card, KCPP will file a health insurance claim form indicating patient payment was received at the time of service. It is your responsibility to ensure KCPP participates with your plan.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days of filing, the responsibility will be transferred to the patient and due upon receipt.

Co-Payments, Deductibles and Outstanding Balances

All copays, co-insurance and deductibles are due at the time of service and will be collected at check-in. If your insurance plan has a deductible amount, we will collect a flat rate of $50 at each applicable service. Copay amounts will be collected in full at the time of service. Copays, deductible and co-insurance are due for all visits, including follow-up visits. All payments are posted to the oldest outstanding balance.

Card on File

Beginning October 19, 2015, we will require a credit / debit /FSA card on file. Your insurance plan is required to send you an Explanation of Benefits (EOB) which will indicate any remaining patient responsibility due. Beginning October 19, 2015, if your insurance carrier assigns any additional patient responsibility amounts after the claim is processed and you do not pay within 30 days, the bank card on file will be used for this payment. You will receive a courtesy call prior to the card being charged and will have the ability to call back to make arrangements for payment. You will have 72 hours to respond to the card to set up an agreeable payment plan or use an alternate method of payment**.**

The safety of your personal information is of utmost importance to us. Our card readers are a service of Commerce bank which uses advanced encryption and tokenization technologies to protect your data. KCPP office staff will have access to only the last four digits of the card number for verification purposes.

Collecting on Accounts

Accounts with outstanding balances over 60 days may be turned over to a collection agency. Once an account has been turned over, we will no longer be able to provide medical care to any family member under your account. Accounts placed with a collection service will need to be paid in full to the collection service. Under these circumstances, the physician may reserve the right to re-establish the patient to an active status in the practice.

Account Consultation

Our providers prefer to defer discussions regarding account balances to our business office. Our business office is trained to discuss your account and make payment arrangements. They will be happy to help you, but if you need further assistance, our Practice Manager may be consulted as well.

Medical Records

We will provide medical records to other practitioners free of charge. However, if you request transfer of your records to any source other than a referral, there will be an upfront fee of "$35.00" to transfer those records in electronic format. If a paper copy of your record is requested, a fee will be assessed based on Missouri state regulation (usually $35-$50). When the request is received and processed you will be notified.

Forms

It is your responsibility to bring required forms to the office for completion such as FMLA, LTD, STD and SSI applications. Please know these forms can take time and require two weeks for completion. There will be a charge of $35 to $100, SSI is charged by the page.

Minors/ Full Time Students

Within the practice of Kansas City Physician Partners, The Center for Rheumatic Disease does not treat minors, but The Center for Allergy & Immunology does. Please know that children under the age of 18 will require the signature of a parent / guardian. Parents / guardians are responsible for payment of all charges incurred by a minor or full time student that are not covered by the insurance company. We will not be responsible for billing or collecting form another party, e.g. divorced or separated spouses. When a patient turns 18, they are required to fill out new forms and are then responsible for their own account.

Returned Check Fee

There will be a $30 returned check fee added to your account if our bank returns your check to us, regardless of the reason. Thereafter, cash or credit card will be the only acceptable forms of payment. Any unpaid returned checks or associated fees will be turned over to a Collection Agency.

Financial Policy Acknowledgement

By my signature below, I authorize Kansas City Physician Partners personnel to communicate my protected healthcare information and account information by mail, phone, answering machine message, text, and / or email according to the information I have provided in my patient registration information.
I have read, understand, and agree to the provisions of Kansas City Physician Partners Financial Policy in full, as evidenced by my signature below.

Signature of Patient / Guardian Relationship (self / guardian) Date

Print Name Patient / Guardian