

# DallasAllergyImmunology

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**PLEASE DO NOT MAIL**

**BRING THIS INFORMATION TO YOUR FIRST APPOINTMENT**

## **THE FIRST APPOINTMENT**

The initial visit involves a comprehensive evaluation focused on your major concerns about you or your child's illness. This will take about 30-60 minutes. Often, laboratory tests are needed in order to come to an accurate and useful diagnosis that will guide treatment. Occasionally lung function tests, x-ray studies, immunizations, or allergy tests may be needed as well. You may meet with a nurse educator. The entire visit may take as long as **three or four hours**.

*You will receive a telephone call from our automatic calling system forty-eight (48) hours prior to your appointment. It is very important that we receive confirmation.*

Every effort will be made to explain the tentative diagnosis and initial plan during the first visit. Most of the time, the information available at the follow up visit is necessary to make the diagnosis and establish the treatment program. Please ask questions about anything that is not clear. Many people find it helpful to bring a written list of questions.

The *typical* charge for initial evaluation is usually \$300, but ranges from \$175 to \$450 depending on the complexity of the problem. Charges for allergy tests, lung function tests, or immunizations related to immunodeficiency evaluation are additional. Laboratory tests and x-rays are billed by the laboratory or hospital and will vary greatly depending on the individual needs of the patient.

At this time, we are members of several HMO's and PPO's; please check with your insurance carrier to verify that we are participating providers. If we are not a provider and you receive a referral to see us from your primary care provider that does not guarantee that we will receive full payment. If you have a question about coverage, call our billing office at 972-566-7669.

As a courtesy, we will file your insurance claim. You will be responsible for the co-pay required by your insurance plan at the time of the visit. If you have not met your insurance deductible, you will be asked for full payment at the time of the visit. You are also responsible for payment of all non-covered charges, at the time of the visit. If there are questions about the fees, please call our billing office at (972) 566-7669.

We understand that illness is always a difficult experience and we will do everything that we can to help. We are looking forward to meeting you.

*Also, if you use an inhaler, please refrain from using this on the day of your appointment.*

Sincerely,



Stacy K. Silvers, M.D.



Robert W. Sugerman, M.D.



Richard L. Wasserman, M.D., Ph.D.

***DUE TO THE NATURE OF OUR PRACTICE WE ASK THAT YOU DO NOT WEAR ANY PERFUME, COLOGNE, SCENTED LOTIONS OR SPRAYS.  
PLEASE DO NOT BRING NUTS OR NUT CONTAINING PRODUCTS TO OUR OFFICE.***

## **PATIENT INFORMATION**

### **APPOINTMENTS AND EMERGENCIES:**

All new patients must confirm their appointment by 12:00 noon the day prior to their scheduled appointment. If your appointment is on a Monday, we request that you contact our office by 12:00 noon on Friday. If we do not receive a telephone call confirming your appointment, it will be cancelled.

Appointments are scheduled by calling (972) 566-7788. If the scheduled appointment cannot be kept, please let us know at least 24 hours in advance so that another patient waiting for an appointment can be seen sooner. If you fail to keep your appointment or cancel in less than 24 hours, you will be billed a \$25.00 fee. Repeated missed appointments may result in discharge from the practice.

Please arrive at the office at least fifteen minutes prior to your appointment so that you can complete or provide additional information needed for your visit.

If there is a problem between appointments, please call and we will decide together if the problem can be handled by telephone or if you or your child needs to be seen immediately or in the next 24 hours for a sick visit. You or your child may be seen by one of our highly trained physician assistants if the physician's schedule is full. A physician is always available to consult with the physician assistant for specific problems. If you are seen by a physician assistant, your Dallas **Allergy** Immunology physician will review the record of that visit.

In the event of a medical emergency, call 911 and then notify our office if time permits. Our physicians have hospital privileges at Medical City Dallas and Children's Medical Center. Life threatening emergencies should be directed to the nearest hospital emergency department. Ask the emergency room physician to call our on-call physician with an update after the patient is seen.

### **TELEPHONE CALLS:**

The office telephone, (972) 566-7788, is answered 24 hours a day.

If you feel that you or your child needs to be seen in the office on the day of the call, let the receptionist know and, if possible, she will work you into the schedule. If the problem is less urgent, you may leave a message on the nurse voice mail. These non-emergency sick calls will be returned the same day. The direct telephone number to the nurse line is 972-566-6144. Other requests will be returned within 24 hours. If you need help sooner, let us know.

Some patients become upset when they call the office and cannot get through to the doctor. We have trained our staff and instructed them to handle all in-coming telephone calls. This procedure allows us to attend to patients with a minimum of interruptions. Please be patient, as this is a courtesy that you would want observed if you were the patient in the office at the time. Your call will be handled as soon as possible, if not immediately. We are very careful about returning phone calls during regular office hours and after hours. If you don't get a telephone call back, there has been an error. Please call again.

We may charge for telephone consultation that take place instead of an office visit. Calls for physician management of a new problem, including counseling, medical management and coordination of care not resulting in an office visit are charged. You will be responsible for any charges that are not covered by your insurance company.

## **SECURE MESSAGING:**

Once you have become a patient at our office you will be able to register for secure messaging through our website. We encourage our patients to use secure messaging to communicate non-urgent medical questions; request appointments or prescription refills; or contact our billing department. A PIN (personal identification number) must be obtained to register. Our staff will be happy to assist you in setting up secure messaging.

## **PRESCRIPTIONS AND REFILLS:**

All medications, including refills are prescribed based on you or your child's current condition. Follow up appointments are scheduled so that we can monitor you or your child's condition and adjust the medicines accordingly. If the last appointment was not kept, refills for a limited period may be given to allow time for a new appointment.

Calls for prescription refills should be made between 9:00 am and 4:00 pm. Your medical record, which is only available in the office, is needed to determine whether a refill should be issued. Therefore, you must keep track of medication needs and call for refills during office hours. Refill requests will be handled more efficiently if your pharmacist calls our Pharmacy Line (972) 566-8107 and leaves a message. Requests left before noon will be called in the same day, requests after 1:00 pm will be called in by noon the following day. Remember that refills may be requested through our secure messaging system.

**Replacement prescriptions for prescriptions that were lost or expired before being filled by the pharmacy will be reissued at a charge of \$15.00 per prescription.**

## **LABORATORY RESULTS:**

Laboratory test results return at different times and may take as long as two weeks. These results are reviewed as they come in. If there is an abnormal result that requires prompt action, we will contact you immediately. Otherwise, simple results may be communicated by a telephone call or our secure messaging system and the results will be discussed in full at your next visit.

## **REQUESTS FOR SPECIAL LETTERS, FORMS, & MEDICAL RECORDS:**

Requests for special letters and forms (e.g., for school, camp, travel or work) should be made through the nurse line or our secure messaging system through our website. Forms may be mailed or faxed. Please include the patient's name, date of birth, and specify the name and address or fax number to which the letter or form is to be sent. When completion of the form requires that the patient's paper medical record be retrieved and reviewed with needed information copied or summarized, a fee of not less than \$5.00 will be charged. Allow 10 business days for letters and forms to be completed and either faxed or mailed.

Written requests for medical records should be directed to our office either by mail, fax, or secure email. Please include the patient's name, date of birth, and specify the name and address or fax number to which the records are to be sent. PDF files can be sent via our secure messaging system at no charge if you are registered with our secure email system. Paper copies will incur a charge of \$25.00 for the first twenty pages and fifty cents per page, thereafter, plus postage. Please allow 15 business days for transfer of medical records.

## **BILLING:**

Full payment is due on the day of service. If the patient is a minor, the patient's accompanying adult, parent, or legal guardian is responsible for payment at the time of services. This includes all insurance copays. We accept cash, checks, Visa, MasterCard, Discover, American Express and debit cards. You can make arrangements for your health care bills to be automatically charged to your credit card. We will charge the credit card each month for the previous month's activity. An administrative staff member can provide more detailed information.

Because our services are personal and directed to you or your child we ask that communications with your insurance company become your responsibility. Our office staff will be happy to answer any questions about the bill and to assist you with your insurance in any way that we can. Call our billing office at (972) 566-7669 for questions or problems.

If you are a member of a pre-paid health plan (HMO, PPO or other insurance) that requires preapproval for the visit, it is **your** responsibility to obtain the referral or authorization. Your plan may also require that tests be performed by a designated facility. It is your responsibility to tell us of this requirement. If the required referral is not obtained, you may be fully liable for the charges associated with the visit.

## **PAST DUE ACCOUNTS:**

An account is considered past due 30 days following billing. There is a \$25.00 late fee applied to your account if we do not receive full payment by the expected due date stated on your statement. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency and/or attorney. All accounts must be current at the time of an office visit.

## **MISSED APPOINTMENTS & SPECIAL PROCEDURES:**

We appreciate the courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty-four (24) hours prior to the appointment time. We will charge a \$25.00 fee for each appointment that is not cancelled at least twenty-four (24) hours before the scheduled time.

Your doctor may order a special procedure such as RUSH Immunotherapy or a food Challenge. These special procedures are performed in our office and require additional medical staff to assist with the procedure. The procedure may also include special supplies or drugs that need to be purchased in advance by our office. RUSH Immunotherapy and food challenges require significant preparation prior to the actual procedure. Therefore, if you are unable to come to the office on the scheduled date, please notify our office immediately. **If you cancel a special procedure less than 48 hours in advance you will be charged \$100.00. This fee is not refundable and will not be billed to your insurance company.**

Patient Information (please print)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

African American \_\_\_\_ American Indian \_\_\_\_ Caucasian/Non-Hispanic \_\_\_\_ Hispanic \_\_\_\_

Oriental/Asian \_\_\_\_ Other \_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Guarantor Information

Guarantor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Mobile Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Other Contacts

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Mobile Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Referred by: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_\_

1<sup>st</sup> Insurance Coverage: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

ID #: \_\_\_\_\_ Group Number #: \_\_\_\_\_

2<sup>ND</sup> Coverage: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security#: \_\_\_\_/\_\_\_\_/\_\_\_\_

ID #: \_\_\_\_\_ Group Number #: \_\_\_\_\_

# DallasAllergyImmunology

## ALLERGY SKIN TESTING INSTRUCTIONS

Allergy skin testing provides a fast, safe and reliable means for identifying allergic sensitivities to inhalant allergens (e.g., pollens, molds, dust mites and animal danders) and is also used sometimes to diagnose allergic sensitivities to insect stings, antibiotics and foods. The information obtained from allergy testing provides guidance for avoidance of allergens, the most important and first step in the treatment of any allergic disorder. Test results may also be used to formulate allergy shot extracts. In order to make your allergy testing appointment as productive as possible, we ask that you review the following instructions prior to your appointment:

1. Although the testing itself may be completed in one hour or less, additional time may be needed to discuss results, allergy avoidance measures and treatment options.
2. Wear a shirt or blouse, which can be removed easily. Prick skin testing is performed using the Multitest™ device applied to the back.
3. The medications listed below will interfere with allergy skin testing and should be discontinued in the time specified. If you have a medical condition or severe allergic symptoms which might worsen without medications, please consult us prior to stopping these medications. If you have forgotten to stop these medications by the specified time, please consult one of our nurses to determine whether or not you need to reschedule your allergy testing appointment.

**ALL OTHER MEDICATIONS NOT LISTED BELOW WILL NOT INTERFERE WITH SKIN TESTING AND SHOULD BE CONTINUED AS PRESCRIBED !!!**

### **DISCONTINUE 10 DAYS PRIOR TO SKIN TESTING:**

Cetirizine (Zyrtec)	Cyproheptadine (Periactin)	Imipramine (Tofranil) **
Levocetirizine (Xyzal)	Doxepin (Sinequan, Adapin)	Chlorpromazine (Thorazine) **
Desloratadine (Clarinox)	Amitriptyline (Elavil) **	Thioridazine (Mellaril) **
Loratadine (Claritin, Alavert)	Nortriptyline (Pamelor, Aventyl) **	Thiothixene (Navane) **
Fexofenadine (Allegra)	Clomipramine (Anafranil) **	Trifluoperazine (Stelazine) **
Hydroxyzine (Atarax, Vistaril)	Desipramine (Norpramin) **	

\*\* IF YOU ARE TAKING A STARRED MEDICATION, YOU MUST FIRST CONSULT WITH THE PRESCRIBING PHYSICIAN TO DETERMINE IF IT IS SAFE TO DISCONTINUE.

**DISCONTINUE 5 DAYS PRIOR TO SKIN TESTING:**

**Chlorpheniramine** (many prescription & OTC brands, including Ah Chew, Chlor-Trimeton, DAllergy, Deconamine, Durahist, Extendryl, Histavent, Omnihist, Rescon, Rynatan, Triaminic Cold & Allergy, Triaminic Multi-Symptom)

**Diphenhydramine** (many OTC brands, including Benadryl, Tylenol PM, Tylenol Cold & Sinus, Triaminic Night Time Cold & Cough, Advil Cold & Sinus, Somnax, Nytol)

**Brompheniramine** (Dimetapp, Bromfed)

**Tripelennamine** (Actifed, PBZ)

**Certain Medications for Motion Sickness / Nausea:** Dramamine, Compazine, Meclizine (Antivert), Phenergan (promethazine)

**Antihistamine Nasal Sprays:** Astelin, Astepro, Patanase. **NOTE: all other nasal sprays are OK!**

**Antihistamine Eye Drops:** Alomide, Livostin, Optivar, Pataday, Patanol

**DO NOT DISCONTINUE THE FOLLOWING MEDICATIONS:**

Medications for Asthma: **including Advair, Flovent, Pulmicort, Qvar, Asmanex, Singulair and Zflo**

**Topical cortisone nasal sprays:** including Flonase, Nasonex, Nasacort, Rhinocort, Veramyst

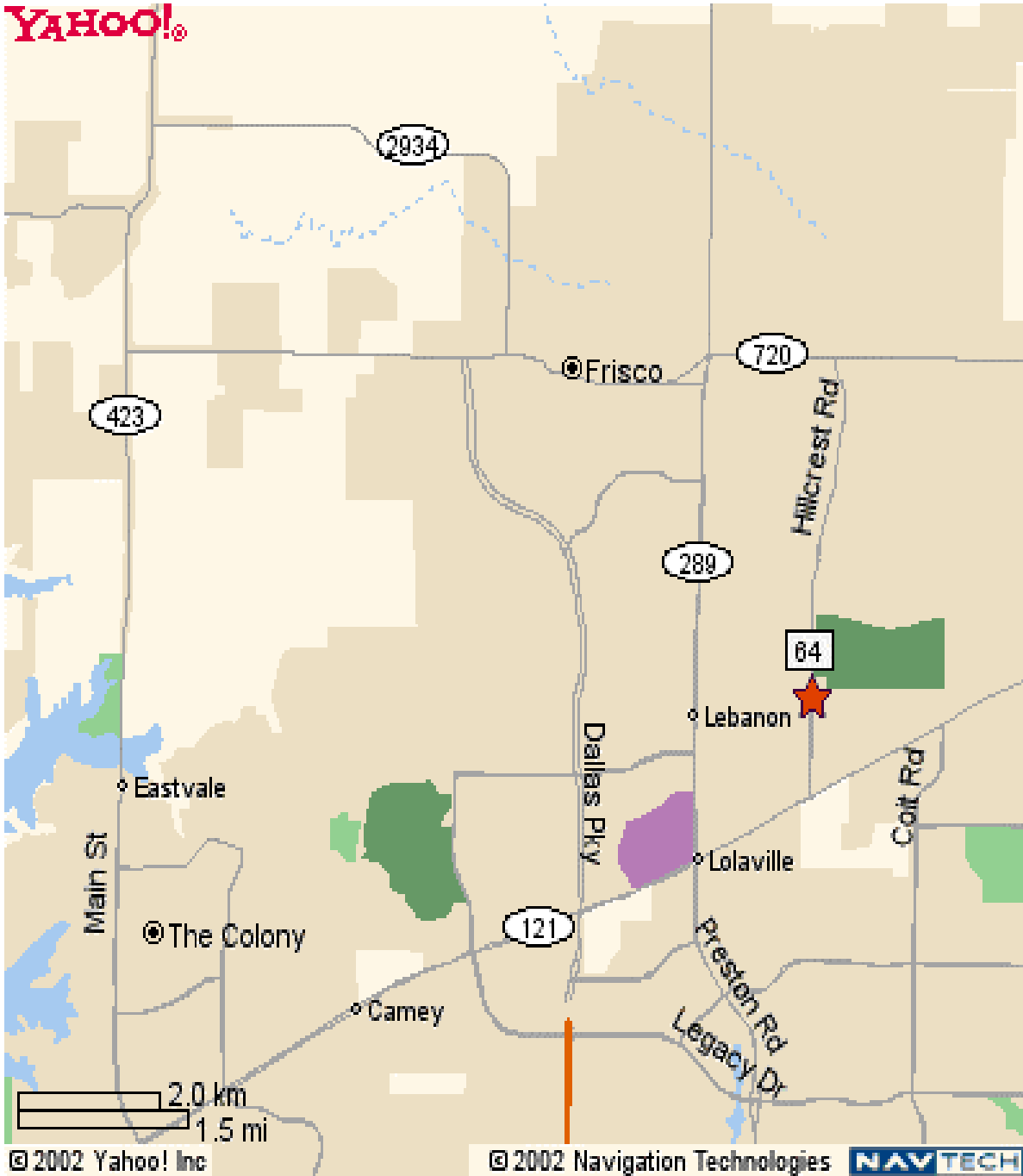
**Medications for acid reflux, high blood pressure and other chronic medical conditions.**

**PLEASE CALL OUR OFFICE AND ASK TO SPEAK WITH A NURSE IF YOU HAVE ANY ADDITIONAL QUESTIONS REGARDING THESE INSTRUCTIONS.**

ALLERGY & ASTHMA ASSOCIATES OF NORTH TEXAS  
4500 HILLCREST, SUITE 150  
FRISCO, TEXAS 75035

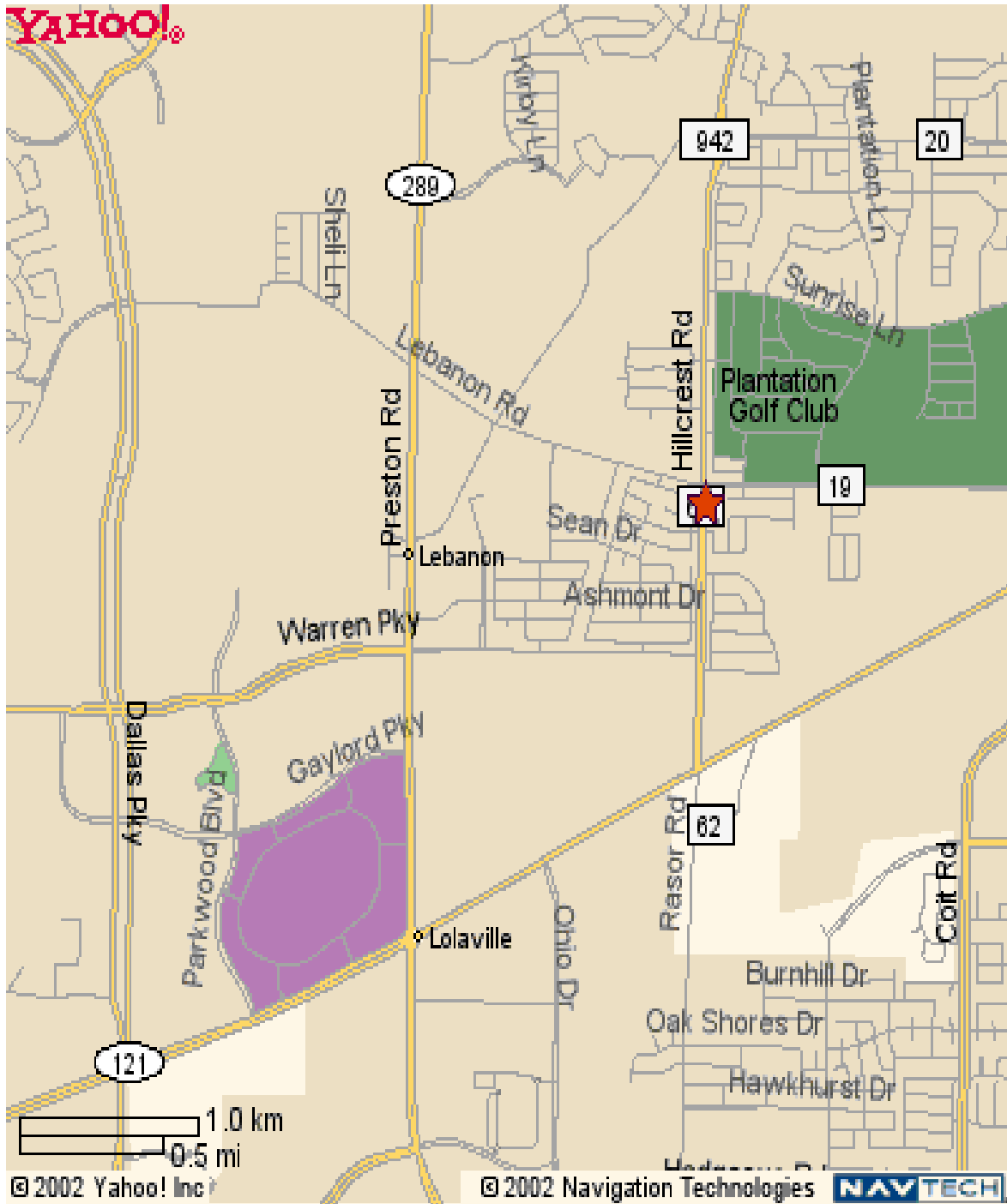


YAHOO!





YAHOO!



# New Patient History

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Chief Complaint (major problem that you would like to solve): \_\_\_\_\_

\_\_\_\_\_

Summary of the major problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medication:** *Please use back of sheet to add additional medications or comments.*

Asthma Drugs (inhaled and oral)	Dose	Daily	As Needed
Allergy Drugs (sprays and oral)	Dose	Daily	As Needed
Eczema Drugs (topicals and oral)	Dose	Daily	As Needed
Other Drugs (including over the counter)	Dose	Daily	As Needed
<b>Epipen Jr.</b> Please circle one <b>YES</b> <b>NO</b>	<b>Epipen</b> Please circle one		<b>YES</b> <b>NO</b>

Any Known Drug Allergies \_\_\_\_\_

What happens when this drug is taken? | Rash | Hives | Other \_\_\_\_\_

**Please use this section to provide any detailed information not included within the questionnaire.**

Additional Asthma history details: \_\_\_\_\_

Additional Allergy history details: \_\_\_\_\_

Previous Allergy Testing: Doctor's Name: \_\_\_\_\_ City: \_\_\_\_\_

Allergy shot reaction details: \_\_\_\_\_

Eczema history details: \_\_\_\_\_

Hives history details: \_\_\_\_\_

Food history details: \_\_\_\_\_

Stinging insect reaction details: \_\_\_\_\_

Infection history: \_\_\_\_\_

Pregnancy/Labor/Delivery problems: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Major Problems/Hospitalizations/Surgeries: \_\_\_\_\_

Social history details: \_\_\_\_\_

Mother's age: \_\_\_\_\_ Father's age: \_\_\_\_\_ Number of brothers and sisters: \_\_\_\_\_

Family History, Additional: \_\_\_\_\_

\_\_\_\_\_

# DallasAllergyImmunology

THE CONSENTS BELOW ARE REQUIRED BY FEDERAL REGULATIONS

\_\_\_\_\_  
Patient Name

With my consent, the physicians may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to this practice's Notice of Privacy Practices for a more complete description of such uses and disclosures. (This permits us to treat you and share information with your other physicians and insurance companies.)

\_\_\_\_\_ (Please initial)  
Yes                  No

I have the right to review the Notice of Privacy Practices prior to signing this consent. The physicians reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy practices may be obtained by forwarding a written request to: Dallas**Allergy**Immunology (DAI), Privacy Officer at 7777 Forest Lane, Suite B332, Dallas, TX 75230. (This says that you know you can ask to see and receive the details.)

\_\_\_\_\_ (Please initial)  
Yes                  No

With my consent, the physician's office 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 may call pertaining to my clinical care, including laboratory results among others. (This permits us to call you and leave a message.)

\_\_\_\_\_ (Please initial)  
Yes                  No

With my consent, this practice may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. (This permits us to send you letters)

\_\_\_\_\_ (Please initial)  
Yes                  No

With my consent, this practice may send secure messages to my home e-mail or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. (This permits us to send secure messages to your email.)

\_\_\_\_\_ (Please initial)  
Yes \_\_\_\_\_ No \_\_\_\_\_

With my consent, this practice may fax to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. (This permits us to send you a fax.)

\_\_\_\_\_ (Please initial)  
Yes \_\_\_\_\_ No \_\_\_\_\_

DAI has an active clinical research program. Many of our patients choose to participate. We will not contact you about research studies without your permission. May we contact you about opportunities we think may interest you?

\_\_\_\_\_ (Please initial)  
Yes \_\_\_\_\_ No \_\_\_\_\_

May we leave information with a spouse, significant other, parent?

\_\_\_\_\_ (Please initial) \_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_ Persons Name

For any patient above the age of 18, still living at home or at college, may we discuss your appointments/treatment/insurance matters with your parent(s) or guardian?

\_\_\_\_\_ (Please initial)  
Yes \_\_\_\_\_ No \_\_\_\_\_

By signing this form, I am consenting to the practice's use and disclosure of my Protected Health Information to carry out Treatment Payment and Health Care Operation.

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, this practice may decline to provide treatment to me. I have read and understand the guidelines of this practice.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

# Dallas**Allergy**Immunology

## Debit/Credit Card Authorization

Dear Patient,

Our office is implementing a new payment policy to help lower the costs associated with our services. Our staff works hard to verify your insurance benefits prior to your visits, making the amount we collect from you at the time of your visit as accurate as possible. We quote the information that we receive from your insurance company.

Your insurance company will be billed for applicable charges for today's services. After an explanation of benefits (EOB) and payment has been received from your insurance company, we will charge your credit card for any remaining balance due. Additionally, if your insurance company has not paid the claim within 90 days, we will charge your debit/credit card for the balance due. Should your insurance company subsequently make payment to our office we will refund your debit/credit card immediately. This policy in no way compromises your ability to dispute a charge or questions your insurance company's determination of payment.

It is our hope that this new policy will work to our mutual advantage since you will no longer have to send a check or give debit/credit card information over the telephone. This will greatly decrease the number of statements generated and mailed each month. Please note that your information will be stored in our secure accounting system.

As always, we strive to provide you with the highest level of care and look forward to continuing to do so.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_

Debit/Credit card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Security code \_\_\_\_\_

Please contact me at \_\_\_\_\_ if payment exceeds \$ \_\_\_\_\_.

By signing this form, I authorize Dallas**Allergy**Immunology to charge my debit/credit card for the balance due on my account.

## NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists may be reported for investigation at the following address:

Se pueden presentar quejas acerca de médicos así también como otras personas autorizadas y registradas por la Junta de Examinadores Médicos de Texas (Texas State Board of Medical Examiners). Incluyendo a ayudantes médicos y acupuntristas, para su investigación, en la siguiente dirección:

Texas State Board of Medical Examiners  
Attention Investigations  
1812 Centre Creek Drive, Suite 300  
P. O. Box 149134  
Austin, TX 78714-9134