

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 972-566-8842.

4500 Hillcrest Road, Suite 150, Frisco, Texas 75035
Telephone (972) 566-7788 | Telefacsimile (972) 566-8837
www.dallasallergy.net

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) 566-8842.

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,



Nana Mireku-Akomeah, 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 EMAIL:

Once you have become a patient at our office you will be able to register for secure email through our website. We encourage our patients to use secure email to communicate non-urgent medical questions; request appointments or prescription refills; or contact our billing department. A separate email account must be maintained for each patient. Our staff will be happy to assist you in setting up secure email.

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 by secure email.

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 secure email 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 by secure email 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 emailed 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) 566-8842 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:(____)____-_____

1st Insurance Coverage: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____)____-_____

Subscriber Name: _____

Sex: _____ Date of Birth: ____/____/____ Social Security #: ____/____/____

ID #: _____ Group Number #: _____

2ND 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 (Clarinet)	Amitriptyline (Elavil) **	Thioridazine (Mellaril) **
Loratadine (Caritin, Alavert)	Nortriptyline (Pamelor, Aventyl) **	Thiothixene (Navane) **
Fexofenadine (Allegra)	Clomipramine (Anafranil) **	Trifluoperazine (Stelazine) **
Hydroxyzine (Ararax, 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 & Zflo**

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

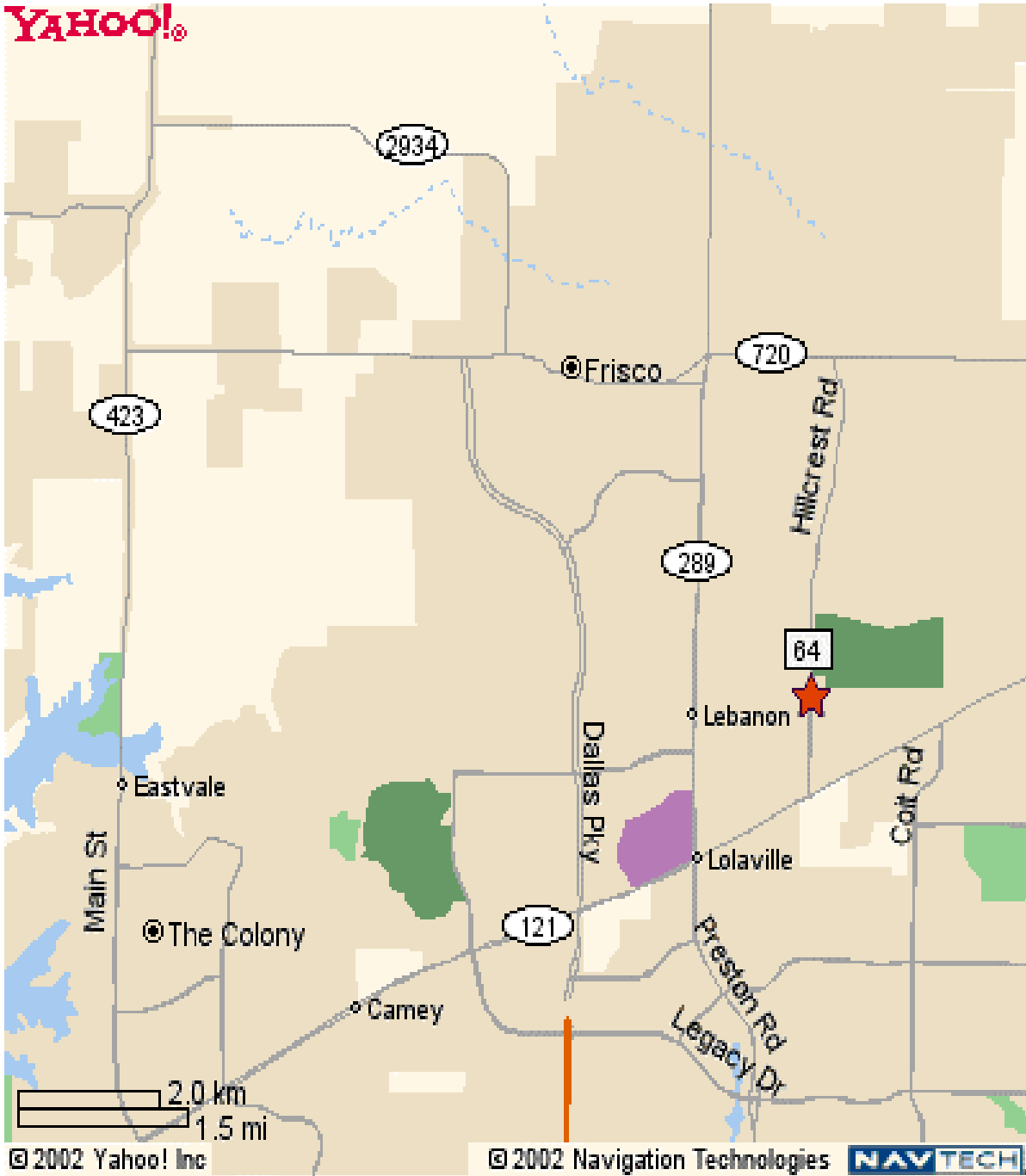
Medications for acid reflux, high blood pressure and other chronic medical conditions.

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

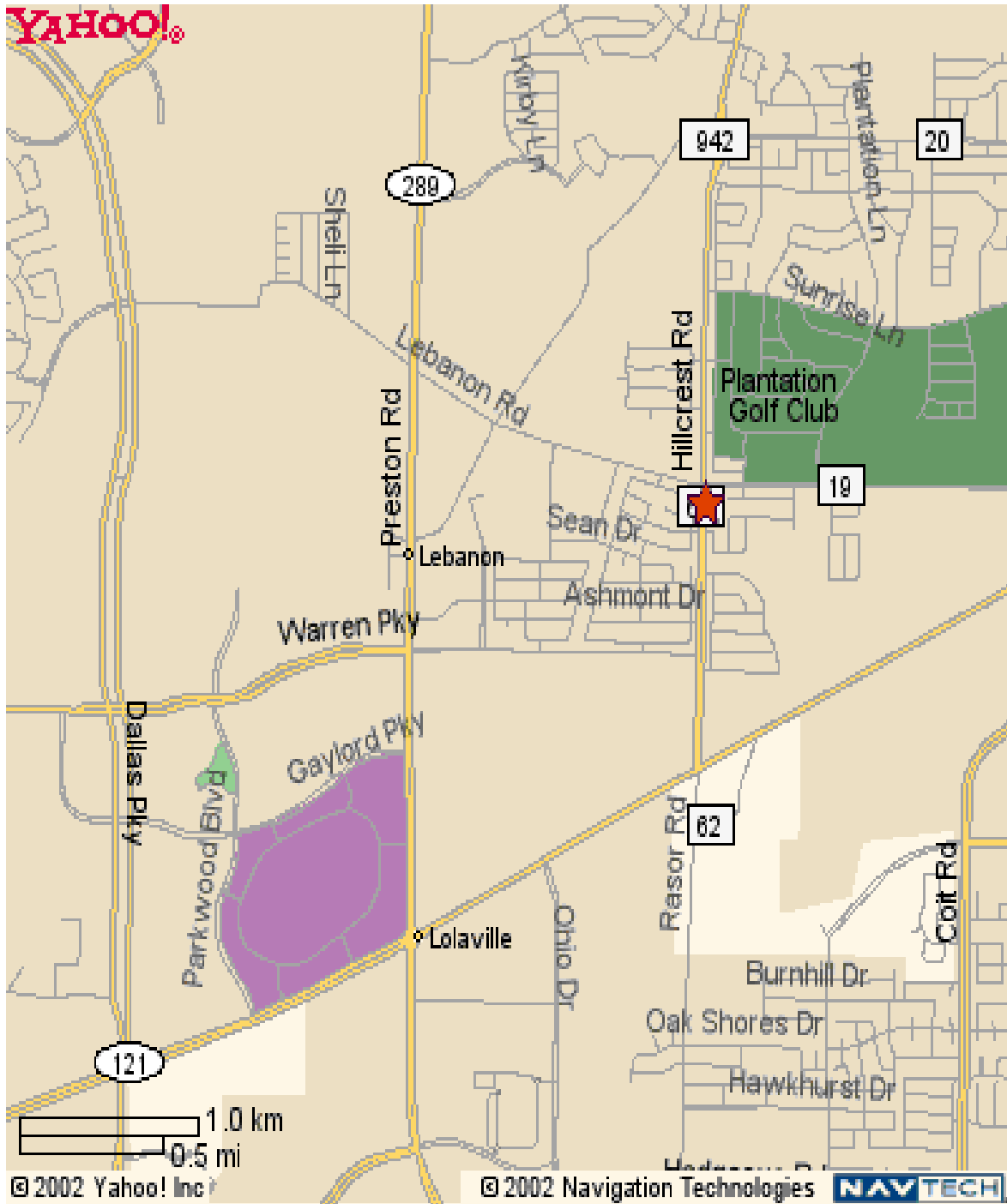


YAHOO!





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 Medications:

Drug	Dose	Daily	As Needed

Medication Allergies: _____

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: _____

Hive 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.)

_____ (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**AllergyImmunology**, Privacy Officer at 7777 Forest Lane, Suite B332, Dallas, TX 75230.(This says that you know you can ask to see 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 as long as they are marked Personal and Confidential. (This permits us to send you letters)

_____ (Please initial)
Yes No

With my consent, this practice may e-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. I have the right to request that this practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.(This permits us to send emails to you.)

_____ (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 as long as they are marked Personal and Confidential. (This permits us to send you a fax.)

_____ (Please initial)
Yes No

From time to time opportunities become available for patients to participate in clinical research studies. These studies are optional, but may be attractive to you. Are you interested in hearing about studies for which you may qualify? (This permits us to let you know about research opportunities.)

_____ (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

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