Welcome to Flatiron Allergy and Asthma Center

We are an allergy, asthma & immunology clinic located in Louisville, Longmont, and Boulder; we are dedicated to providing the highest quality allergy & immunology care to our patients.

During your consultation, our physicians will obtain a detailed medical history, complete any allergy related testing (if indicated), and formulate an individualized treatment plan that best empowers you to feel confident about managing your allergic or immunologic disease.

In preparation for your consultation, we kindly request that you complete and bring with you the following information:

**Demographics:**
- Identification (Driver’s License)
- Insurance Card
- Patient Registration Form
- Referral Letter (if required by insurance company)
- Co-pay/Payment (if required)
- Financial Policy Form
- General Policy
- HIPAA/Privacy Acknowledgement Form

**Clinical:**
- Completed New Patient Form
- Allergy Skin Test Consent Form
- Review the Preparation for Allergy Skin Test Form
- Office Records from the Referring Physician (if applicable)
- List of Current Medications and Medication Allergies
- Recent Chest X Rays and CT Sinus Reports/Films (if applicable)

We are pleased that you have chosen us for your care and look forward to meeting you.

Sincerely,

The Staff of Flatiron Allergy and Asthma Center
PATIENT REGISTRATION FORM

For Office Use Only
Patient # ___________________________ Location ___________________________
Date of First Appointment ___________________________ Patient ID Verified ☐

Patient Information

Patient's First Name _________________________ M.I. ________ Last Name _________________________
Address _____________________________________________________________________________________________
Street                          City                          State                          Zip
Home Phone ___________________ Cell Phone ___________________ Social Security # ___________________________
Date of Birth _____ / _____ / _____ Email ___________________________
MM              DD              YYYY
Gender: M / F  Marital Status: Married Single Divorced Other
Ethnicity: Non-Hispanic/Latino Hispanic/Latino Race: Caucasian African American Asian Other
Employer ______________________________________________ Work Phone ___________________________________
Emergency Contact __________________________ Relationship ______________________ Contact Phone _____________
Primary Care Physician __________________________________ Referred by ___________________________

Insurance Information

Primary Insurance __________________________________ Group Number ___________________________
Member ID ___________________________ Insured Date of Birth ___________________________
Insured Name ___________________________ Relationship to Patient ___________________________
Insured Employer _____________________________________________________________________________
Secondary Insurance __________________________________ Group Number ___________________________
Member ID ___________________________ Insured Date of Birth ___________________________
Insured Name ___________________________ Relationship to Patient ___________________________
Insured Employer _____________________________________________________________________________

Responsible Party

First Name _________________________ M.I. _______ Last Name _________________________
Address _____________________________________________________________________________________________
Street                          City                          State                          Zip
Home Phone ___________________ Cell Phone ___________________ Social Security # ___________________________
Date of Birth _____ / _____ / _____ Email ___________________________
MM              DD              YYYY
Relationship to Patient __________________________ Work Phone ___________________________
Employer ___________________________ Work Phone ___________________________

I authorize the release of medical information necessary to process claims or obtain treatment. I request payment of benefits to Flatron Allergy and Asthma Center. I understand I am financially responsible for charges not paid by my insurance.

I understand and agree that if my treatment at Flatiron Allergy and Asthma Center requires primary care physician referral, it is my responsibility to see that the referral is current and valid prior to receiving care at Flatiron Allergy and Asthma Center. If no referral is present in advance, I agree to pay for charges at the time of service.

Patient/Responsible Party Signature ___________________________________________ Date _______________________
Relationship to Patient ____________________________________________________________

UPDATED 02.13.19
PRIVACY PRACTICES

Flatiron Allergy & Asthma Center
Principal Location: 90 Health Park Dr. Suite 170. Louisville, CO 80027
Holly Lohr - Office Phone: 303.862.3303

Acknowledgement of Receipt of Notice of Privacy Practices
I have reviewed this medical practice's current Notice of Privacy Practices as posted in the reception area.

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient

I authorize the following persons to consent for needed treatment in my absence for
_______________________________________________ (Minors only)

Name: ______________________________ DOB: ________________
_______________________________________________ _____________________
_______________________________________________ _____________________
_______________________________________________ _____________________

Communication of Medical Issues: such as test results, you can choose more than one

☐ Phone ( ) ___________________ □ OK to leave a message including results or other health related information

☐ Not OK to leave a message

☐ U.S. Mail

Verbal Communication of Protected Health Information

I authorize the following individuals to inquire and receive verbal information regarding my care and sign a records release.

(Actual release of medical records requires a separate form)

1. ______________________________ Relationship ____________ Date of Birth ______________

2. ______________________________ Relationship ____________ Date of Birth ______________

Signature of Patient or Guardian: _________________________________________________

Print Name: __________________________________________________________________

Date: ___________________________ Telephone: ___________________________________
FINANCIAL POLICIES

Please understand that Flatiron Allergy and Asthma Center’s (FAAC) financial policies are established to ensure the financial resources needed to maintain this medical office for all our patients. We must emphasize that as a health care provider our relationship is with you and not your insurance company.

It is your responsibility to inform our office of any patient information changes including name, address, and insurance information.

Please read and sign the following financial policies indicating your understanding of these policies and accepting financial responsibility for all services provided. Please ask us if you have any questions about our fees, policies, or your responsibilities.

Insurance

- The patient is required to present an insurance card at each visit. It is the patient’s responsibility to make sure that all insurance information given to our office is correct and current, including both primary and secondary insurance. Failure to provide us with correct insurance information could result in your insurance company rejecting your claims for failure to obtain authorization, timely filing or other reasons and may result in your responsibility for the entire bill.

- FAAC will bill your insurance company. It is your responsibility to verify your coverage and adhere to the restrictions of your plan. Your insurance is a contract between you, your employer if applicable, and your insurance company. Please contact your insurance company and/or your employer’s human resource department with regards to your benefit questions. Although we may estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility and benefits.

- You may be responsible for charges incurred in this office that are not paid by your insurance company, including those applied to your deductible or coinsurance, in accordance with FAAC’s fee schedule and terms, regardless of insurance coverage. We don’t always know if you have a deductible, if your deductible has been met, or if you have coinsurance.

- We expect payment in full of deductible and coinsurance balances within 30 days of statement receipt unless prior payment arrangements have been made. If services are performed or appointments made that are not covered by your insurance plan, you may be responsible for payment. We may ask that non-emergency appointments be rescheduled if copayment is not paid.

- I authorize my insurance company to make payments directly to FAAC. I authorize the release of any medical information necessary to process claims and/or pursue payments of this account.

Self-Pay or Insurance FAAC does not participate with

- You will need to sign a self-pay waiver if you have no insurance. This waiver clarifies your financial responsibly and helps prevent misunderstandings.

Referrals

- It is your responsibility to list a physician if your insurance company requires a PCP and call for a referral if one is required. Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist.

- Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance may be your responsibility.
**Imaging and Laboratory Fees**

- Imaging and Laboratory services are performed and billed by an outside provider. You will be billed from their office and all payments, questions or other concerns should be directed to their office. Flatiron Allergy and Asthma cannot accept payments or adjust these outside provider charges.

**Cancellations**

- There is a $25.00 charge for no shows or cancellations within 24 hours of your scheduled appointment.

**Minor Patients**

- The parent/guardian accepts financial responsibility for all services provided by FAAC to a minor patient, regardless of who is the subscriber on the insurance policy.

- Payment of services is due by the adult accompanying any minor child unless other arrangements have been made in advance.

- FAAC will not bill two people for care of a minor patient. It is the responsibility of the accompanying adult to pay the amount due in full, and collect what is owed by others.

- FAAC is not party to any legal agreements between divorced or separated parents and therefore is not bound by the terms of any such agreements.

**Returned Checks**

- There will be a $25.00 charge in addition to any charged bank fees for returned checks. This fee will be applied to my debit/credit card on file. All future payments must be paid with a debit/credit card.

**Payment**

- I understand that FAAC requires that a credit card (we accept Visa, Mastercard, and Discover), debit card or health savings account card be kept on file and will be billed for any balance owed by the patient.

- If the credit card or health savings account card I provide on file is declined, I understand that I will be charged an extra $25 re-processing fee.

- Accounts past due are subject to collection proceedings and ultimately dismissal for full collection accounts.

I take responsibility for researching the costs of my visit and any procedures related to the visit with my insurance company and understand that costs not covered by certain insurance will be charged to me. I understand that I can discuss any visit related charges ahead of the visit with Flatiron Allergy and Asthma Center’s billing department at 970-430-4896.

I have read and accept the terms of this financial policy.

_____________________________________________________
Printed Name of Financial Responsible Party

_____________________________________________________
Signature of Financially Responsible Party

_____________________________________________________
Date
CREDIT CARD ON FILE AUTHORIZATION FORM

Keeping a credit card on file has its benefits:
It’s convenient (saving you time and postage).
Your payment is always on time (even if you’re out of town).
You can get your credit company’s reward points for paying your bill.
You SAVE money by avoiding late fees.

Here’s How it Works:

You authorize Flatiron Allergy & Asthma Center to keep your credit card number on file and use it to bill any outstanding balances after third parties pay their portion.

Once all third parties, including your medical insurance, have paid their portion you will receive a statement and have 30 days to review it before your card is charged.

You will receive a reminder call a week before we charge your card. A message will be left if we reach your voicemail.

I ___________________________________________ authorize Flatiron Allergy & Asthma Center to charge my credit card indicated below for my outstanding balance on an as needed basis.

<table>
<thead>
<tr>
<th>Billing Address</th>
<th>Phone Number</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>City, State &amp; Zip Code</th>
<th>Email Address</th>
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</table>

Patient Names (list all)

I authorize Flatiron Allergy & Asthma Center (FAAC) to charge the credit card indicated in this authorization form according to the terms outlined above. I understand I may revoke this authorization by providing a written request at least 15 days prior to my card being processed. I understand that FAAC policy is to have a credit card on file for payment and if authorization is revoked without providing another credit card, FAAC may not be able to provide future services. I understand that this authorization will remain in effect until the designated card's expiration date or until I cancel it in writing, whichever comes first, and I agree to notify FAAC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I understand that should my credit card be declined, I may be subject to a $25.00 re-processing fee. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form. I agree to promptly submit written notification to Flatiron Allergy & Asthma Center if my credit card is cancelled, lost or stolen.

Signature:__________________________________________________________

Date:_________________________
GENERAL POLICIES

Thank you for choosing Flatiron Allergy & Asthma Center (FAAC) as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your understanding of our policies is important to our professional relationship.

1. I understand that medications are unable to be refilled if I have not followed up within the requested interval.

2. I understand that I may be charged for telephone calls to the provider.

3. I may be asked to reschedule if I am more than 10 minutes late for my appointment.

4. I understand I will be charged a fee of $5 for the completion of each page on a school form. School forms will be not charged if it is brought in during a scheduled office visit.

5. I understand I will be charged fees in accordance to Colorado law for copies of my medical records.

6. I understand I will be charged a fee of $25 for each letter prepared by FAAC.

Signature of Patient (or Parent/Guardian for Minor Patient)  Date

Printed Name of Patient
Today’s Date _____________________________ Pharmacy Name and Location __________________________
Patient’s Name ___________________________ Referring MD: ____________________________________
Date of Birth _______________________ Primary Care Provider: ______________________________
It is ok to send you appointment reminders through email:  Yes / No
How did you hear about our practice?
- Primary Care ______________  - Current Patient ______________  - Google ______________
- Specialist _______________  - Family Member/Friend _____________  - Internet ____________
- Insurance Company ____________  - Facebook _______________  - Other __________________

Reason for Visit: __________________________________________________________

**Medical History (Please Circle)**

- Allergies
- Anemia
- Anxiety/Depression
- Asthma
- Autoimmune Disease
- Bleeding Disorder/Clots
- Cancer
- Cataracts/Glaucoma
- COPD/Emphysema
- Diabetes
- Eczema
- GI Diseases including EOE
- Heart Attack
- Heart Disease
- Heart Failure

**Immunization History:**

- Date/Year of Last Flu Shot:____________________
- Date/Year of Last Pneumonia Shot: ____________

**Social History:**

- Marital Status: _____________
- Occupation: ________________
- Hobbies/Interest: ________________
- Smoking: Never/ Current/ Former
  - If so, How Much ________
  - How Long ________
- Quit Date _________
- Alcohol: Never __ Rare __ Social __ Daily __
- Marijuana and/or Recreational Drug Use? Yes/No

**Food Allergy/Reactions:**

- Latex Allergy: Yes/No
- Insect Adverse Reaction: Yes/No
  - If so, to: Bee/ Wasp/ Yellow Jacket/ Hornet/ Fire-ant Mosquito/ Other
- Eczema: Yes/No
  - If so, triggers: Environmental/ Chemical/ Metal/ Food

**Current Pregnancy:** Yes/ No

**If Patient is a child:**

- Child Lives with: ____________________________
- Mother/Father’s Full Name: __________________
- Mother/Father’s Full Name: __________________
- Attends Daycare: Yes/No
- Exposed to second-hand smoke: Yes/No
- Birth History: Vaginal/C-Section
- Birth Weight: ___________ pounds

Updated 3.4.19
# Family Medical History

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Mother</th>
<th>Father</th>
<th>Children</th>
<th>Siblings</th>
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<tbody>
<tr>
<td>Angioedema (swelling)</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Drug Allergy</td>
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<td>Eczema</td>
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<tr>
<td>Hives</td>
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### Past Allergy Testing:
- Never Tested Before
- Prior Skin Test: Yes/No - Year: ____________
- Prior Blood Test: Yes/No - Year: ____________
  - Allergic to: pollen/dander/food/chemicals/venom/other
- Prior Allergy Shots: Yes/No - Year: ____________
- Currently on Allergy Shots: Yes/No

Date of Last Sinus CT Scan: ____________
Date of Last Chest X-ray: ____________

**Environmental History**

Where do you live? City/ Country/ Farm/ Rural
- Is your home: Single Family/ Apartment/ Condo/ Townhome/ Mobile Home
- How long have you been in Colorado? __ months/years
- Heating: (Circle One) Gas/ Electric/ Baseboard/ Forced Air/Fireplace (wood burning/gas/electric)
- Cooling: Air Conditioner/ Swamp Cooler/ Window Fan
- Flooring: Hardwood/Carpeting/Other: ____________
- Mattress: Spring/Foam/Waterbed/Other. Years old: ____________
- Pillow: Feather/Foam/Synthetic. Years old: ____________
- Visible Mold or Water Damage? Yes/No
  - If Yes: Mild/Moderate/Severe
- Humidifier? Yes/No
- Setting: ____________
- Air Purifier: Yes/No
- Do you have pets or animal exposure?
  - Type of animal(s): ____________

**Drug Allergy/Reaction:**

- ____________
- ____________
- ____________

**Current Medications OR BRING A CURRENT LIST**

<table>
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<tr>
<th>Medication</th>
<th>Name</th>
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**Review of Systems: (Please Circle)**

- General/Constitutional: fatigue, fevers, headache, recent illness, weight gain, or weight loss
- Eyes: contact lenses/glasses, disease or injury, itchy, pain, redness, watering, vision change
- Ears/Nose/Throat/Neck: frequent sinus infections, hearing loss, itchy nose, nasal stuffiness, bleeding, pain, post-nasal drip, ringing of ears, runny nose, sneezing, snoring, masses in thyroid
- Cardiovascular: chest pain, heart murmurs, or hypertension
- Respiratory: cough, respiratory infections, shortness of breath, or wheezing
- Gastrointestinal: abdominal pain, constipation, diarrhea, difficulty with swallowing, indigestion/heartburn, nausea, or vomiting
- Genitourinary: frequency, infections, or urgency
- Musculoskeletal: limitation of motion, pain, or swelling
- Skin: dryness, eczema, hives, itching, or rash
- Neurologic/Psychiatric: anxiety, depression, or seizures
- Endocrine: diabetes, glandular problem/thyroid disorder, or intolerance to heat or cold
- Hematologic: anemia, bleeding tendency, or previous transfusions and reactions
- Allergic/Immunologic: frequent infections, reactions to: foods/insects/medications/vaccine

Date of Last Lung Test: ____________

Updated 3.4.19
PATIENT CONSENT FORM FOR ALLERGY SKIN TESTING

Purpose:
Allergy skin testing is performed to assess for allergy antibodies to:

- environmental allergens (pollen, animal proteins, dust mite, mold, cockroach)
- food allergens
- insect venoms (honeybee, yellow jacket, yellow hornet, white faced hornet, paper wasp, fire ant)
- medications such as penicillin

Procedure:
Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a hive (swelling and redness). The results are read at 15 to 20 minutes after the application of the allergen. The skin test methods are:

Prick:
In prick allergy skin testing, a sharp plastic lancet is passed through the allergenic extract or control solution, the skin on the back or forearm is lifted and a small break in the epidermis is created through which the extract or solution penetrates. If an allergenic sensitivity is present, a hive/welt like reaction develops in the area of prick.

Intradermal:
Intradermal allergy skin testing is most commonly completed adjunctively to negative prick testing in evaluation of environmental, venom, and drug allergy. In intradermal skin testing, a small needle is used to inject the allergenic extract or control solution into a deeper layer of skin, called the dermis, on the arm. If an allergenic sensitivity is present, a hive/welt like reaction develops in the area of intradermal application.

Interpretation:
Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient’s clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so.

Risks:
Skin testing will be administered at this medical facility with a medical physician or other health care professional present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of a reaction to the allergy testing and beta-blockers are medications they may make the treatment of the reaction to skin testing more difficult.

Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.
Alternatives:
Allergy skin testing is considered superior and less expensive than specific IgE blood tests in the diagnosis of allergy.

After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment.

Please do not cancel your appointment since the time set aside for your skin test is exclusively yours for which special allergens may be prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours-notice. Due to the length of time scheduled for skin testing, a last-minute change results in a loss of valuable time that another patient might have utilized.

I have read the patient information sheet on allergy skin testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient_______________________________________ Date signed__________

Parent or legal guardian*_________________________ Date signed__________
*as parent or legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.

Witness ______________________________________ Date signed__________
PREPARATION FOR ALLERGY SKIN TESTING

As part of your allergy consultation, allergy skin testing maybe indicated. The interpretation of these tests can be adversely affected by use of antihistamine medications and those medications with antihistaminic activity.

To best ensure a high-quality allergy skin test, it is necessary to avoid the following medications as listed below:

Please discontinue the following medications, as well as any over-the-counter allergy & sinus medications for at least 5 days prior to your visit:

- Alavert (Loratidine)
- Alaway (Ketotifen)
- Allegra (Fexofenadine)
- Astepro (Azelastine)
- Azelastine
- Atarax (Hydroxyzine)
- Chlortrimeton (Chlorpheniramine)
- Clarinex (Desloratidine)
- Claritin (Loratidine)
- Dimetapp (Brompheniramine)
- Dymista (Azelastine + Fluticasone)
- Nyquil (Doxylamine)
- Optivar (Azelastine)
- Patanase (Olopatadine)
- Tavist (Clemastine)
- Vistaril (Hydroxyzine)
- Xyzal (Levocetirizine)
- Zaditor (Ketotifen)
- Zyrtec (Cetirizine)
- Zyrtec Itchy Eyes (Ketotifen)

Please discontinue the following medications for at least 2 days prior to your visit:

- Axid (Nizatidine)
- Benadryl (Diphenhydramine)
- Pepcid (Famotidine)
- Tagamet (Cimetidine)
- Zantac (Ranitidine)

The application of topical steroids to the forearms and back should be avoided for at least 2-3 weeks prior to your visit.

Medications such as benzodiazepines, tricyclic antidepressants, as well as other antidepressants may suppress responses to skin testing. If you are on these medications, please contact the prescribing physician and inquire if these medications can be safely stopped.

You can continue to take inhaled, nasal, and oral steroids without interfering with allergy skin testing.

Allergy skin tests are generally safe, but rarely life-threatening allergic reactions may occur. Symptoms of such reactions can include hives, swelling, breathing troubles, and low blood pressure.

Due to this risk, it is important that you let us know if you have a history of anaphylaxis, unstable asthma, are pregnant, and/or are on beta blockers, ACE inhibitors, or MAO inhibitors. Having these conditions, being pregnant, or being on these medications may make a rare allergic reaction to skin testing more severe and/or more difficult to treat.