NEW PATIENT HISTORY SHEET

I. PERSONAL DATA:

Name: _____ Birthdate: _____

II. MAJOR ALLERGIC SYMPTOMS:

What type of allergy problems do you have? _____

How long have you had these problems? _____ How frequently? _____

Are you being treated for any other medical problems? _____ If so, by whom? _____

What medications do you take and how frequently? _____

_____

Have you ever been treated for allergies? _____ Have you ever taken allergy shots? _____

Have you ever had an allergic reaction to medicines/drugs? _____

If so, what type of reaction? _____

III. SYMPTOMS: PLEASE ANSWER ALL QUESTIONS!

Do you seem to have problems more in the:
Spring _____ Summer _____ Fall _____ Winter _____ All the time _____

Did your problems begin: Suddenly _____ Gradually _____

Are your problems worse in the: Morning _____ Afternoon _____ Night _____

Which parts of the body are more affected by your allergy symptoms/problems:
Head _____ Eyes _____ Nose _____ Ears _____ Chest _____ Skin _____ Intestinal _____

Are your symptoms affected by:
Dust _____ Pollens _____ Animals _____ Feathers _____ Mold/Mildew _____ Smoke _____
Time of Year _____ Air Conditioning _____ Strong Odors _____ Weather Changes _____
Foods/Diet _____

IV. FAMILY HISTORY:

Has anyone in your family had allergies, asthma, hay fever or sinus problems? Please check:
Mother _____ Father _____ Brothers/Sisters _____ Other Relatives (specify) _____

Is there a history of any other serious medical problem/s? _____

If so, what? _____

V. SOCIAL HISTORY

Smoking:
Do you currently smoke? Yes _____ No _____

If so, how many cigarettes/day? _____ For how long? _____

Have you ever smoked? Yes _____ No _____

If so, how many cigarettes/day? _____ How long? _____ Quit _____ years ago

Does anyone in your household smoke? Yes _____ No _____ Whom? _____

Alcohol
Do you drink alcohol? Yes _____ No _____

If so, what type? Liquor _____ Wine _____ Beer _____

How many drinks/day? _____ Week _____ Month _____ Year _____

VI. ENVIRONMENTAL HISTORY

Do you have any pets in the home? Yes _____ No _____

If yes, how many Cat _____ Dog _____ Birds _____ Rodents _____

Do they stay inside or outside? _____

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ALLERGY & ASTHMA CENTER OF HILTON HEAD

First Name: _____ MI: _____ Last Name: _____

AKA (name you go by): _____

Parent/Guardian's Name (if minor): _____

Pt. Social Security Number: _____-_____-_____ Date of Birth: _____ Gender: M F

Street Address: _____ City/State/Zip: _____

Secondary Address: _____ City/State/Zip_____

Contact Numbers: Home: _____ Work: _____ Cell: _____

Fax: _____ Email: _____

Race: _____ Ethnicity: _____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Emergency Contact Person: _____ Phone: _____

Address (if different than patient) _____

Relationship: _____

Employer: _____ Occupation: _____

Drivers License - State/Number: _____

Referring Physician: _____

Primary Physician: _____

Pharmacy: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Name on Policy: _____ Relationship: _____

Sponsor's Name: _____ Sponsor's Date of Birth: _____

Sponsor's Social Security Number: _____-_____-_____

ALLERGY AND ASTHMA CENTER OF HILTON HEAD

FINANCIAL RESPONSIBILITY AGREEMENT

Payment is expected at the time of service. Payment may be made using cash, check or credit card (MasterCard or Visa). Any deductible, co-insurance or co-payment is payable at the time of service.

PAYMENT GUARANTEE: The undersigned agrees, whether signing as a patient or guarantor, to guarantee payment of the account in accordance with the standard rates and terms of The Allergy and Asthma Center of Hilton Head. I understand that my insurance, if any, is a contract between myself and the insurance company, except in certain cases when this office has a specific contract with an insurance company. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay.

In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney or both, I agree to be responsible for and pay, in addition to the charges for services and treatment received, all costs reasonably associated with such collection activity including but not limited to reasonable collection fees, skip tracing cost, court costs and attorney fees.

The Allergy and Asthma Center of Hilton Head may also check credit reports and report unpaid balances to credit bureaus. The Allergy and Asthma Center of Hilton Head reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions.

It is not customary for physician's to discuss the cost/s of medical procedures unlesss asked. If you want to know what the fee of a particular procedure is, please ask before the procedure is performed.

New Patients: If skin testing is performed, we may collect $250.00 to cover a portion of the cost of this test, especially if your annual deductible has not yet been met. By signing this form, you are verifying that you understand this may not cover the entire fee for tests performed.

THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THIS FINANCIAL RESPONSIBILITY AGREEMENT.

Patient Name (Printed): _____

Patient/Parent/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

ALLERGY AND ASTHMA CENTER OF HILTON HEAD
Thomas C. Beller, MD
60 Main Street, Suite D
Hilton Head Island, SC 29926
Phone: 843-689-6442 Fax: 843-689-6158

RELEASE OF INFORMATION

I hereby authorize The Allergy and Asthma Center of Hilton Head to release all medical information to all my insurance carriers, Medicare or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability or Workman's Compensation or for other insurance purposes.

I have read and understand the following forms:

1) HIPAA Notice of Privacy Practices
   We are required bylaw to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number. (Initial _____)

2) Communications
   It is acceptable to leave messages regarding appointments and test results on my answering machine/voice mail and/or with a family member. (Initial _____)

3) Patient ID Card
   I have chosen to store my Patient ID Card in the box supplied by the above named practice with other individual's cards. (Initial _____)

My signature below is only acknowledgement that I have received the Allergy and Asthma Center's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

ALLERGY AND ASTHMA CENTER OF HILTON HEAD
60 Main Street, Suite D
Hilton Head Island, SC 29926
Phone: 843-689-6442 Fax: 888-397-1781

All co-pays, deductibles and non-covered fees are collected the day of your visit.

Our office will file the claim with your insurance company. It is your responsibility to provide us with the necessary authorization/referral if your plan requires one.

Please do not ask us to provide a discount or adjust your co-pay, co-insurance or deductible for our services.

Our contracts REQUIRE us to collect these fees from you.

Attorney Alan Wilson states that billing "Insurance Only" and non-collection of patient's "responsible fees" is considered filing a false claim once the the claim has been filed with the insurance company. State law Chapter 55, Section 38-55-170 list the penalties, including fines and possible incarceration, that a physician could face for filing a "false claim".

If you are unable to provide us with your responsible portion today, please ask to speak with either the Practice or Accounts Manager prior to being seen.

There will be a **$35.00** fee for returned checks.

Patient Name (Printed): _____

Patient/Parent/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

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Skin Test Scheduling Agreement

If Dr. Beller orders testing (skin or challenge), I understand that this appointment requires a significant amount of time to be blocked on the schedule of the Allergy & Asthma Center. If I am unable to keep this appointment for any reason, I agree to cancel it at least 24 hours in advance. I also agree to pay a **$50 cancellation/no-show fee** if I cancel the appointment within 24 hours of the scheduled time or if I do not show up for testing. I understand that this fee will not be covered by my insurance.

_____ _____

(Signature) (Date)

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