ALLERGY & ASTHMA CENTER

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: _____ Cell: _____ Preferred #: Home ___ Cell ___

Email address: _____(Required)

Race: _____ Ethnicity: _____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Emergency Contact Person: _____ Phone: _____

Address (if different than patient) _____

Relationship: _____

Drivers License - State/Number: _____

Referring Provider: _____

Primary Provider: _____

Pharmacy: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Name on Policy: _____ Relationship: _____

Tricare Only:
Sponsor's Name: _____ Sponsor's Date of Birth: _____
Sponsor's Social Security Number: _____-_____-_____

TCB/ljsn
2022

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? _____

Do you have a history of: Diabetes ____ Coronary Artery Disease _____ Hypertension _____ Prostate _____ Cancer _____

Other _____

Have you ever been hospitalized? _____ If so, for what? _____

Have you had any surgeries? _____ If so, what type? T&A _____ Sinus _____ Hysterectomy _____ Prostate _____

Orthopaedic _____ Appendix _____ Other _____

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? _____

Have you ever had an allergic reaction to **foods**? _____

If so, what type of reaction? _____

Have you ever had an allergic reaction to **insect stings**? _____

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? _____

TCB/AHB/ljsn
2022

ALLERGY AND ASTHMA CENTER

FINANCIAL RESPONSIBILITY AGREEMENT

Payment is expected at the time of service. Payment may be made using cash, check or credit card. Any deductible, co-insurance or co-payment is payable prior to services rendered.

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. I understand that my insurance, if any, is a contract between the insurance company, and myself 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 & Asthma Center will report any unpaid balances to credit bureaus.

If you want to know the fee of a particular procedure, please ask prior to the procedure is performed and **check with your insurance company to verify coverage.**

New Patients: **If skin testing is performed, we may collect a $350.00 deposit at the time of service** to cover a portion of the cost of this test, especially if your annual deductible has not yet been met. Please understand this deposit **may not cover the entire fee for testing performed.**

MISSED APPOINTMENTS AND/OR LATE CANCELLATION fees of $25 - $50 will be incurred and will be the responsibility of the patient/parent/guardian. (New Patient appointments - $50, Follow Up appointments - $25 and Skin Test appointments - $50)

RELEASE INFORMATION

I hereby authorize The Allergy and Asthma Center 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 Workers Compensation or for other insurance purposes.

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

Patient Name (Printed): _____

Patient Signature: _____

Relationship to Patient: _____ Date: _____

TCB/ljsn
2025

ALLERGY AND ASTHMA CENTER
Thomas C. Beller, MD
60 Main Street, Suite D
Hilton Head Island, SC 29926
Phone: 843-689-6442 Fax: 888-397-1781

I have read and understand the following forms:

1) HIPAA Notice of Privacy Practices
We are required by law 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 _____)

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: _____

TCB/ljsn
2022

ALLERGY AND ASTHMA CENTER
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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 claim has been filed with the insurance company. State law Chapter 55, Section 38-55-170 lists 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 fee today, please ask to speak with either the Practice or Accounts Manager prior to being seen.

There will be a $40.00 fee for all returned checks.

Patient name (Printed): _____

Patient/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

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For the FCR Collection Services:

I understand if I have an unpaid balance to the Allergy & Asthma Center and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all cost and expenses, including reasonable collection and attorney's fees incurred during the collection efforts.

In order for the Allergy & Asthma Center or their designated external collection agency to service my account, and where not prohibited by application law, I agree that the Allergy & Asthma Center and the designative external collection agency are authorized to:

1) contact me by telephone at the number/s I am providing including wireless telephone numbers, which could result in charges to me,
2) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and
3) methods of contact may include using prerecorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Furthermore, I consent the designed external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, email and mail notification.

Patient Name (Printed) _____

Patient/Guarantor Signature: _____

Relationship to Patient: _____ Date: _____