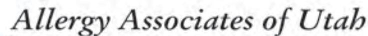

Fashion Place Location
6095 Fashion Boulevard, Suite 100
Murray, Utah 84107
801-263-8700 • Fax 801-263-8693

Jordan Landing Location
3855 West 7800 South, Suite 225
West Jordan, Utah 84088
801-282-8700 • Fax 801-282-3305

Thank you for choosing Allergy Associates of Utah for your medical care.

Please complete the included allergy questionnaire and return it by mail (if time permits) or bring it with you to your appointment. If you do not have time to complete it before your appointment, please arrive at our office at least 30-45 minutes early so you will be ready in time for your appointment. If you would like to send in your paperwork or any additional medical records electronically, please contact our office, and the staff will walk you through the process.

Please make sure to bring a current copy of all active insurance card(s) and your identification/driver's license to the appointment.

AN ALLERGY EVALUATION CAN TAKE UP TO TWO-THREE HOURS. Please do not schedule any other appointments that may conflict with your allergy appointment.

The provider may perform testing to evaluate your medical condition. The type and number of tests may vary depending on the medical problem.

If testing needs to be performed, you should **AVOID** the following allergy medications for the specified times:

- Claritin (Loratadine), Allegra (Fexofenadine), Zyrtec (Cetirizine), Clarinex, Xyzal, Hydroxyzine, Vistaril – **72 hours**
- Benadryl (Diphenhydramine), Lodrane (Bromphenaramine), Chlorpheniramine, DAllergy, Allerx – **48 hours**
- Any other antihistamine or anti-itch pill, cough/cold medication, or allergy pill – **Check with the office**
- Astelin (Azelastine), Astepro, Dymista, or Patanase (Olapatadine) Nasal Spray – **48 hours**
- Patanol (Olapatadine), Pataday, Zaditor (Ketotifen), Optivar (Azelastine), Elestat (Epinastine), or other anti-histamine allergy eye drops – **48 hours**
- Zantac (Ranitidine), Pepcid (Famotidine) – **48 hours**

YOU SHOULD NOT STOP ANY OTHER MEDICATIONS, INCLUDING ASTHMA MEDICATIONS, STEROIDS, OR ANTIBIOTICS, UNLESS DIRECTED BY A HEALTH CARE PROVIDER. If you have any questions, please call our office before your appointment.

We routinely contact your insurance for a good-faith estimate of your benefits for our most routine tests and procedures. We will discuss with you when these tests may be medically beneficial.

Copayments for specialist office visit services are due at time of service and/or a good-faith estimate of your deductible and coinsurance as determined by your medical plan at the time of service. Any questions or payment arrangements can be made with the Business Office prior to your visit at (801)263-8700, option 1.

Please notify our office at least 24-48 hours before your appointment if you are unable to keep it. We look forward to meeting you and helping you with your medical care.

Sincerely,

Allergy Associates of Utah
www.utahallergies.com
office@utahallergies.com

ALLERGY ASSOCIATES OF UTAH

Patient Information

Name: ____ Date of Birth: _____ / _____ / _______ Date: _____ / _____ / _______

Address: ____ City: ________________ State: ________ Zip: _________________

Home Phone: __________________ Cell Phone: __________________ Occupation: ____

Emergency Contact: ____

Relationship: __________________ Phone: ____________________ Address: ____

Personal Physician: ____ Referred by: _____________________________________

Please list other family members who have been seen in this practice: ____

Responsible Party

IF THE PATIENT IS AN **ADULT**	IF THE PATIENT IS A **MINOR**
Employer: ____________________________	Responsible party name: ____________________________
Work Phone: ____________________________	Address: ____________________________
Spouse: ____________________________	City: ______________ State: ________ Zip: __________
Employer: ____________________________	Home Phone: ____________________________
Work Phone: ____________________________	Employer: ____________________________

Insurance Information

1st Insurance Company: ______________________________

Subscriber Name: ______________________________

Subscriber Date of Birth: ______________________________

Subscriber ID#: ______________________________

Subscriber Group#: ______________________________

2nd Insurance Company: ______________________________

Subscriber Name: ______________________________

Subscriber Date of Birth: ______________________________

Subscriber ID#: ______________________________

Subscriber Group#: ______________________________

NOTE: IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, PLEASE GIVE YOUR CURRENT, COMPLETED REFERRAL FORMS FROM YOUR PRIMARY CARE PHYSICIAN AS WELL AS YOUR INSURANCE ID CARD TO THE FRONT DESK BEFORE YOU SEE THE DOCTOR. IT IS YOUR RESPONSIBILITY TO COMPLY WITH THE TERMS OF YOUR CONTRACT WITH YOUR INSURANCE COMPANY.

CREDIT POLICIES

1. PAYMENT IS REQUESTED AT THE TIME OF TREATMENT UNLESS SPECIAL ARRANGEMENTS ARE MADE.
2. PAYMENT ON ACCOUNTS BILLED IS EXPECTED WITHIN 30 DAYS.

No finance charge will be made unless the account is not discharged as per agreement. I/We acknowledge this agreement and agree to pay collection costs and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection suit.

Patient/Parental Signature: ____ Date: _____ / _____ / __________

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MEDICAL & FINANCIAL INFORMATION AUTHORIZATION & RELEASE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual 's office instead of the individual's home. We will release information ONLY by the authorized means you have chosen. We will take reasonable steps to limit the use or disclosure of and request for PHI co the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. We will keep a record of all PHI disclosures. Uses and disclosures may be permitted without prior consent in an emergency.

I authorize the staff of Allergy Associates of Utah to release any **financial** information to the following people:

Name of Spouse: ____
Partner: ____
Parent or Guardian: ____
Other: ____

I authorize the staff of Allergy Associates of Utah to release any **medical** information to the following people:

Name of Spouse: ____
Partner: ____
Parent or Guardian: ____
Other: ____

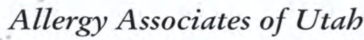
Please check all that apply:

Telephone Communication:	Written Communication:
☐ Home telephone:	☐ OK to mail to my home address
☐ Cell phone:	☐ OK to mail to my work/office address
☐ OK to leave detailed message on answering machine	☐ OK to fax to this number:
☐ OK to leave message with call back number only	☐ OK to mail promotional material
☐ Work telephone:	☐ OK to mail information regarding research studies
☐ OK to leave detailed message on answering machine	☐ Other/list any restrictions:
☐ OK to leave message with call back number only	

I have received the Notice of Privacy Practices of Allergy Associates of Utah and I have been provided an opportunity to review it. I understand l may revoke any part of this authorization at any time by giving written notice to the Privacy/Security Officer at Allergy Associates of Utah.

Patient (or legal representative) name: ____

Signature: ____ Date: ____ / ____ / ______



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Electronic Communication Policy

Patient Name: ______________________________ Date of Birth: ___ / ___ / _____ Date: ___ / ___ / _____

☐ I would like to sign up for the **Onpatient patient portal** and receive e-mail reminders for my clinical care.

E-mail address to be used: ____

☐ I would like to receive text message reminders for my clinical care.

Phone number to be used: ____

☐ I **DECLINE** electronic communication.