Clear Allergy

Name:_____ **DOB:**_____/_____/_____

The main reason(s) for visit:_____

Drug allergies:

Most recent flu shot:

Adverse reactions to: Food?

Latex? Insect sting? (circle all that apply)

History of: Recurrent infections? (sinusitis, bronchitis, pneumonia, ear infections)

Nasal polyps?

Asthma?

Atopic dermatitis (eczema)?

Do you experience any of these symptoms? No - please write *none.* Yes - please briefly explain.

Rash:

GERD / Acid Reflux / Heartburn:

Stress:

Urticaria (hives):

Angioedema (swelling):

Snoring:

Difficulty breathing / cough (circle those that apply):

Difficulty hearing and/or congestion in ears:

Neck pain / headache / back tension (circle all that apply):

Sensitivity to (circle all that apply): smoke / perfume / strong odor

Environmental/Social History:
I live in a House / Condo / Apartment in the city of _____.
I have lived there for _____ years.
Pets:

(Circle all that apply)
Factors that provoke my symptoms:
dust / changes in weather / cat / dog / windy condition / cut grass / damp environment / old leaves / smell of house cleaning chemicals / smell of cosmetics / smell of paint

My bedroom floor is made of wood / carpet / tile / other.

I have dust mite covers on pillow / comforter / mattress / I do not have dust mite covers on anything.

History of cigarette smoking:

Alcohol intake: _____ drinks daily / weekly / monthly

At night, I keep the windows open / closed / open and closed dependent on the weather

I spend time on upholstered couches and chairs: Y/ N

I have a down comforter: Y / N

I have a HEPA filter: Y / N

***Preferred Pharmacy:**_____
***Address:**_____
***Phone:**_____ ***Fax:**_____

Insurance - Patient Relationship to Guarantor:

| Self | Spouse | Child | Other |

IF OTHER THAN self, please fill out below -
Guarantor name:_____
Guarantor phone number:_____
Guarantor address:_____
Guarantor date of birth:_____/_____/_____

Current Medications:

Name:	Dosage:	Frequency:	Start Date/Yr:

Clear Allergy

CLEAR ALLERGY ("CLEAR")
FINANCIAL POLICY AND CONSENT FOR DISCLOSURE

Insurance and Payment: I understand that I am financially responsible for the payment for any services provided and that the submission of any claim to my insurance plan is as a courtesy to me by CLEAR. I acknowledge that I have confirmed with my insurance plan what coverage and benefits I am entitled to for an allergy/immunology specialist, (including in-network vs. out-of-network benefits). I further understand that it is my responsibility to continue to verify such coverage prior to each visit to ensure I am aware of any changes. If I am unable to provide proof of insurance, I understand and agree that I will be considered a **"cash"** patient and responsible for full payment at time of service.

Co-payments, Co-insurances, Deductibles, Non-covered Services: I understand that CLEAR may or may not have a contract with my insurance plan. In order to determine whether CLEAR is a contracted (in- network) provider*, I agree it is my responsibility to contact my insurance carrier and ask if CLEAR, located at 3831 Hughes Ave, Ste 600A, Culver City, CA 90232* is a contracted provider. I further understand that CLEAR may be required to bill me for any applicable Copayments, Co-insurances, Deductibles or Non-covered Services as directed by my insurance plan. I understand that CLEAR has a legal and contractual obligation to bill me these items and may not be permitted to adjust and/or waive any amounts owed by me. **Such adjustment or waiver is not permitted by CLEAR and would be in direct violation of CLEAR's contracts with such insurance plans and could jeopardize CLEAR's, and the physician's participating provider status.**

Payments Collected at the Time of Service: Because many PPO insurance plans have annual deductibles and CLEAR cannot verify if such deductibles have been met, I understand that CLEAR will require payment from me at the time of my visit (see below). I understand that if I have a HMO plan, I must have a proper documented referral/authorization by my insurance before receiving services. Not providing such information at the time of my appointment will result in you being classified as a **"cash"** payment and full payment will be required prior to the provision of services.

X-RAYS and LABS: I understand that any radiology (x-rays), and/or blood work ordered by the physician will not be performed in the *CLEAR ALLERGY* office, and I will be referred to an outside non-affiliated facility which I may go to, or, may choose another provider of my choice. I understand that while these tests may be ordered by the physician, it is my responsibility to understand my insurance coverage for these services.

INITIALS

In-Office Testing (e.g. Skin Testing): If you have a deductible for any testing performed by CLEAR in its office, such as skin testing (including patch testing), please be prepared to pay a $250.00 deposit at the time of service.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE FINANCIAL POLICIES OF THIS MEDICAL OFFICE AND UNDERSTAND MY FINANCIAL RESPONSIBILITY. I ALSO AUTHORIZE AND ASSIGN MY INSURANCE BENEFITS THAT MAY BE PAYABLE TO ME TO BE PAID DIRECTLY TO CLEAR. I FURTHER AUTHORIZE THE RELEASE OF INFORMATION REQUIRED TO PROCESS AN INSURANCE CLAIM AND TO CARRY OUT TREATMENT.

Signature:_____ **Date**:_____

Print Name:_____ **Relation to Patient**_____

3831 Hughes Ave Ste 600A, Culver City, CA 90232

P 424.603.4544 | F 424.603.4546 | www.Clear-Allergy.com

Patient Preference for Disclosure of Personal Medical Information

Patient's Last Name: _____ First:_____ DOB:_____

The HIPAA privacy law gives individuals the right to request restrictions on users and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means.

Please read and mark those forms of communication listed below that you personally approve for disclosure and discussion of protected health information. Please put a checkmark on all the contact boxes with your preferences.

Communication with person(s) other than the patient:
Is there a power of attorney? ☐ Yes ☐ No (If yes, please provide us a copy)

May we discuss your condition with anybody else? ☐ Yes ☐ No (If yes, please list the names and relationship to you.)

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Patient Contact Information

Home Phone Number:_____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

Cell Phone Number:_____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

Please list any other phone numbers we can call: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

If you would like your medical information to be faxed to you when requested in the future, please provide us your fax number. If no fax number is provided, then you'll have to sign a separate release form in the future in order for us to send your medical information to you via fax.

Fax#_____

Unless otherwise revoked, or an alternative expiration date is provided here, this authorization is valid for ONE YEAR from the date listed below.

Initials: ☐

*I grant permission to **CLEAR ALLERGY** to relay, leave messages and fax me with detailed information regarding my personal health information with the person(s) and contact number(s) and information listed above.*

PRINT Patient (or Parent) Name:_____ Signature: _____Date:_____

Notice of Privacy Practices

Acknowledgement of Receipt

CLEAR ALLERGY

(424) 603-4544

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Patient Name:_____

Name of Parent/Guardian (if applicable)_____

Signed: _____Date: _____

Telephone: _____ Email: _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

***I would like to receive a copy of any amended Notice of Privacy Practices by email, at:**_____

_____

***For Office Use Only*:**

☐ Signed form received by: _____

☐ Acknowledgment refused/Reason for refusal: _____

Efforts to obtain: _____

_____

Katie Marks-Cogan, M.D., FACAAI
Raffi Tachdjian, M.D., MPH, FAAAAI
3831 Hughes Ave Ste 600A
Culver City, CA 90232
P 424.603.4544 | F 424.603.4546
Clear-Allergy.com

CANCELLATION AND SERVICE FEES

I understand that if I hold a PPO/EPO insurance, or am SELF-PAY status (Medicare and IPA patients excluded), I am financially responsible for the payment of the listed services below.

Cancellation Policy: Due to being a small office, we maintain a strict cancellation policy. If an appointment is not canceled more than 24 hours in advance, it prevents other patients waiting to be scheduled for an appointment. Because of this, cancellation within 24 hours (or no-show) of your appointment will be subject to a charge of seventy-five dollars ($75) to the card number provided below; this charge will not be covered by your insurance company.

Other Non-covered Services: Please understand the services below are considered courtesy services and will not be covered by your insurance, and are therefore subject to $10.00 upfront by credit card on file:

1. **Medical Letters of Necessity** (e.g. Travel letters, apartment/housing, special circumstances, etc.)
2. **School/Summer Camp Forms** (**exceptions include same-day school absence form)*
3. **Personal copies of medical records** (*2+ pages*)
4. **Retroactive Claim Letters for Laboratory or Imaging Services** (**as these are separate business entities from Clear Allergy*)
5. **Transfer of Antigen Serums to an outside allergist** *(*subject to a shipping and handling fee starting from $30.00)*

I authorize Clear Allergy to charge my credit card (Clear Allergy will inform patient prior to charging):

Credit Card Number:_____
Expiration Month/Year: _____/_____
3 or 4-digit Security Code:_____

Name on Card:_____
Billing Zip Code:_____
Telephone #:_____

I have read the above information and understand my financial responsibilities.

Signature: _____ Date: _____

Print Name: _____