ALLERGY & ASTHMA CENTER OF THE ROCKIES

RECORDS RELEASE

WILLIAM A. LANTING, MD

FORT COLLINS: 1029 ROBERTSON ST 80524

GREELEY: 8223 W.20 ST SUITE B 80634

FORT MORGAN: 1000 LINCOLN ST

STERLING: 1405 S. 8". AVE SUITE 102

FORT COLLINS OFFICE: (970) 227-4611 **FORT COLLINS FAX:** (970) 282-1785

GREELEY OFFICE: (970) 978-4114 **GREELEY FAX:** (970) 978-4264

I DO HEREBY AUTHORIZE MY PHYSICIAN TO: OBTAIN RECORDS OR SEND RECORDS :

PLEASE CHECK WHICH ONE YOU ARE REQUESTING

PLEASE **PRINT** THE FULL NAME, ADDRESS AND PHONE NUMBER OF THE PHYSICIAN OR FACILITY		
RELEASE THE RECORDS INDICATED:		OFFICE APPOINTMENT NOTES
		LABS/XRAYS/CT SCANS/SPIROMETRY/ETC
		IN-OUT PATIENT REPORTS
		ALLERGY SERUM
		COMPOSITION SHEET / INJECTION RECORD
		INJECTION HISTORY
		ALL RECORDS

PATIENT'S FULL NAME-PLEASE PRINT ______ DATE OF BIRTH ______ DATE ______

PATIENT OR GUARDIAN SIGNATURE ______

WITNESS INITIALS ______ DATE ______

DATE RECORDS SENT/ PICKED UP: ______________________

ALLERGY & ASTHMA CENTER OF THE ROCKIES

FINANCIAL POLICY

Please understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you to ensure that your medical care does not become a financial burden. We will gladly bill your insurance company for any covered services.

We must emphasize that as a health care provider our relationship is with you, not your insurance company.
Your insurance is a contract between you, your employer, and the insurance company.
Contact your insurance company and/or your employer's human resource department with regards to your benefit questions.

PATIENT RESPONSIBILITIES:

Insurance Card(s): We require a copy of your current insurance card upon every visit and with every antigen order. We also require your signature and a current card with every antigen order.
Co-payments: **Co-payments are due at time of service.**
Referrals: If your insurance requires a referral, and you do not provide one at the time of service, you are responsible for any charges incurred. It is your responsibility as the insured to obtain a referral.

Cancellations:
For all appointments there is a 24 hour cancellation notice requirement.
There is a $25.00 charge for repeated late cancels or no shows, that can ultimately result in dismissal from the practice.
If you have health insurance with which we participate:

- We will bill your insurance claim for you.
- We expect any required co-payment at time of service.
- We expect payment of deductible and coinsurance to be paid in full after we have issued you a statement to be paid within 25 days unless prior payment arrangements have been made.

If you are uninsured or we do not participate with your insurance:

- We require you to sign an uninsured form.
- Payment for total charges are due on the day of your appointment unless you have signed a Payment Plan with our office.

General:
Payment of services is due by the person accompanying any minor child unless other arrangements have been made in advance. We will not bill two people for care. It is the responsibility of the accompanying adult to pay the amount due in full, and collect what is owed by others.

We accept payments in cash, check and credit card (VISA, MASTERCARD). Post-dated checks are acceptable within 2 weeks and will be deposited on the check date.
If payment arrangements need to be made, they must be made prior to any service and payment in full must be within 90 days. Accounts over 90 days are subject to collection proceedings. I understand that should account be turned over to collections I may be held responsible for any and all collection, legal and attorney fees incurred. Account balances are to be kept under 60 days old, or further services (ie: injections, office visits) may not be provided until payment is made in full or a payment plan with a credit card on file is agreed upon.

- **There will be a $25 charge for returned checks.**
- **I have read and accept the terms of this financial policy.**
- **I understand this pertains to current and any future treatment I receive.**

I authorize the release of medical information necessary to process claims or obtain treatment. I authorize payment be made directly to the clinic for services provided. I understand I am responsible for services not reimbursed by my insurance. I understand I am responsible for obtaining referrals for services needed and I will be charged for those services received without a referral in place. If payment arrangements need to be made, they must be made prior to any service or immediately upon receipt of initial statement; payment in full must be made within 90 days. Accounts over 90 days, or any missed payment of your payment arrangement, are subject to collection proceedings.

Date: ___________________________ Signature: ____

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ALLERGY & ASTHMA CENTER OF THE ROCKIES
HIPAA NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW CAREFULLY

Our Company's Pledge To You
This notice is intended to inform you of the privacy practices followed by Allergy & Asthma Center of the Rockies. It also explains the federal privacy rights afforded to you and the members of your family.

As a medical provider, Allergy & Asthma Center of the Rockies often needs access to health information in order to provide treatment, obtain payment and function in your best interest. We want to assure you that we comply with federal privacy laws and respect your right to privacy. Our staff has been trained to follow these policies. Third parties that are provided access to health information comply with the privacy practices outlined below.

Uses and Disclosure of Health Information

Health Care Operations - Your health information may be used, as necessary, to support the day-to-day activities and management of our clinic. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Payment- Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, that you may use to pay for services, provided, and the medical condition being treated.

Treatment- Staff members for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment, offering treatment alternatives may use your health information.

Appointment Reminders- We may use and disclose medical information to contact you as a reminder that you have an appointment.

As permitted or required by law- We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that my be of interest to you, respond to a court order, or provide information to further public health activities (e.g. reporting diseases to the state's public health department) without your written authorization. We are also permitted to share health information during a corporate restructuring such as merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization When required by law, we will ask for your written authorization before using disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures. In all cases we will do our best to provide only the minimum medical information necessary to fulfill the request, unless otherwise directed to do so.

Individual Rights

Right to Inspect and Copy- In most cases you have a right to inspect and receive copies of the health information we maintain about you. If you request copies, we will not charge for the initial set, but reserve the right to charge for any mailing fees and additional copies. Your request to review your health information must be submitted in writing to the address listed below.
Right to an Accounting of Disclosures- You have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes.
Right to Amend- If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information. Although the right to request a change exists it does not constitute an adjustment on our behalf. If the request is denied, you will receive a written reason for denial.
Right to Request Restrictions- You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.
Right to Request Confidential Communications- You have the right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address. This request must be made specifically for each instance.
Right to Receive a Paper Copy of this Notice- If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person below.

Our Legal Duties
We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, please call (970) 227-4611.

Complaints If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the number above. You also may send a written complaint to the U.S. Department of Health and Human Services – Office of Civil Rights.

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ALLERGY & ASTHMA CENTER OF THE ROCKIES DEMOGRAPHIC FORM

PATIENT INFORMATION:	
PATIENT NAME:	DATE OF BIRTH:
NICKNAME:	SOCIAL SECURITY:
GENDER: MALE FEMALE	MARITAL STATUS: M S D W
HOME ADDRESS:	
CONTACT NUMBER HOME:	
CONTACT NUMBER CELL:	
CONTACT NUMBER WORK:	
EMPLOYER NAME & ADDRESS:	
OCCUPATION:	
PRIMARY CARE PHYSICIAN:	
REFERRING PHYSICIAN:	
Text Reminder:____Yes ____No	Please list phone number for texted reminders:

INSURANCE:	
NAME OF POLICY HOLDER:	POLICY HOLDER DATE OF BIRTH:
ID:	GROUP #:
RELATIONSHIP TO PATIENT:	PHONE # OF POLICY HOLDER:
SOCIAL SECURITY # OF POLICY HOLDER:	
ADDRESS:	

PARENT/GUARDIAN/EMERGENCY CONTACT:
1. NAME:
DATE OF BIRTH:
RELATIONSHIP TO PATIENT:
CONTACT NUMBER:
ADDRESS:

GOVERNMENT REQUIREMENT: (PLEASE CIRCLE)	**HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE)**
AFRICAN ALASKAN NATIVE AMERICAN INDIAN ASIAN CAUCASIAN LATINO	FRIEND INSURANCE VALPAK NEWSPAPER DOCTOR INTERNET OTHER

ASSIGNMENT OF BENEFITS: I authorize Medicare and/or any other insurance plans under which I am covered to make payment to Allergy and Asthma Center of the Rockies or its Assignee of authorized benefits on my behalf, for products or services furnished to me. I understand that by signing this agreement, I accept financial responsibility for the deductible, co-insurance, co-payments and all non-covered charges.

RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary to verify benefits, process claims, or provider appropriate care of related services provided by Allergy and Asthma Center of the Rockies or its Agents. I acknowledge the receipt of the Privacy Practices for Allergy and Asthma Center of the Rockies.

______________________________ ______________________________

Signature **Date**

______________________________ ______________________________

Printed Name **Date of Birth**

MEDICAL INFORMATION

NAME:	DATE OF BIRTH:
LOCAL PHARMACY:	

LIST PRESCRIBED MEDICATION AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

MEDICATION, STRENGTH & HOW OFTEN:	6.
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.

ALLERGIES TO MEDICATIONS OR FOODS	REACTION YOU HAD	REACTION TO BEE, HORNET, WASP OR MOSQUITO
1.		
2.		
3.		
4.		

LIST MEDICAL PROBLEMS OR PRIOR DIAGNOSED DISEASES OR ISSUES

LIST HOSPITALIZATIONS

YEAR	SURGERIES	ER VISIT	HOSPITALIZATION OVER NIGHT STAYS

PAST ALLERGY THERAPY

YEAR:	WHAT KIND OF TESTING:	IMMUNOTHERAPY: Y N # YEARS:	OTHER THERAPY:

MEDICATION S THAT HAVE BEEN TRIED & FAILED:

FAMILY HEALTH HISTORY	PLEASE LIST WHAT FAMILY MEMBER
ALLERGIES	
ARTHRITIS	
ASTHMA	
CANCER (WHAT KIND)	
COPD	
DIABETES	
ECZEMA	
HEART ATTACKS/STROKES	
HYPERTENSION	
IBS/COLITIS	
MIGRAINES	
REFLUX	
THYROID	
OTHER:	

HEALTH HABITS

Do you drink alcohol? Y N What kind? How many drinks per week?	Exposed to second hand smoke? Past Present None Do you use tobacco? Past Present Year Quit None
Do you currently use recreational or street drugs? Y N	Cigarettes – pks #/day Chew - #/day Cigars- #/day
Past and Present Occupation:	Exercise: Minutes a week: Type:
Marital Status: M S W D	

ALLERGY & ASTHMA CENTER OF THE ROCKIES

Environmental History

NAME:	DOB:

HOME

- WHAT TYPE OF HOME DO YOU LIVE IN? SINGLE FAMILY APARTMENT TOWNHOUSE; OWN RENT
- AGE OF HOME?____________
- HOW MANY YEARS HAVE YOU LIVED AT THIS RESIDENCE?______________
- WHAT OTHER PARTS OF THE COUNTRY HAVE YOU LIVED IN?________________________
- HEATING SYSTEM? FORCED AIR OIL HOT WATER ELECTRIC WOOD STOVE FIREPLACE
- COOLING SYSTEM? AIR CONDITIONER SWAMP COOLER OPEN WINDOWS
- DO YOU HAVE A HUMIDIFIER? YES NO
- IS YOUR HOME MOSTLY CARPETED? YES NO
- WHERE IS YOUR HOME LOCATED? RURAL URBAN SUBURBAN
- DO YOU HAVE WATER DAMAGE OR MILDEW IN THE HOME? YES NO

BEDROOM

- DO YOU HAVE BEDDING OR FURNITURE MOVED HERE FROM ANOTHER PART OF THE COUNTRY? YES NO
  IF YES, WHICH STATE?______________________
- DO YOU HAVE CARPETING OR LARGE RUGS IN THE BEDROOM? YES NO
  IF YES, WHAT TYPE ARE THEY? COTTON WOOL SYNTHETIC
- DO YOU HAVE A DOWN COMFORTER? YES NO

BED

- ARE YOU SLEEPING ON A BED ON THE FLOOR? YES NO
- WHAT IS YOUR MATTRESS MADE OUT OF? FOAM FEATHERS SYNTHETIC
- WHAT IS YOUR PILLOW MADE OUT OF? FOAM FEATHERS
- DO YOU HAVE EXTRA PILLOWS ON YOUR BED? YES NO
- DO YOU HAVE STUFFED ANIMALS ON YOUR BED? YES NO

INDOOR PETS

- DO YOU HAVE ANY PETS WITH FUR OR FEATHERS? YES NO
  IF YES, WHAT TYPE? DOG CAT BIRD HAMSTER RABBIT OTHER_____________
- DO YOUR PETS SLEEP IN YOUR BED OR BEDROOM ON THE FLOOR? YES NO
- DO YOU HAVE OUTDOOR ANIMALS? YES NO

SMOKING HISTORY

- HAVE YOU EVER SMOKED? YES NO
  IF YES, HOW MANY YEARS___________ PACKS PER DAY______________
- DO YOU CURRENTLY SMOKE? YES NO
- ARE YOU READY TO QUIT SMOKING? YES NO
- HAVE YOU BEEN EXPOSED TO SECOND HAND SMOKE? YES NO
  IF YES, HOW MANY YEARS?____________

OCCUPATION / ACTIVITIES

- AT WORK WHAT ARE YOU EXPOSED TO? SMOKE DUST CHEMICALS FUMES FARM PRODUCTS ANIMALS
- WHILE DOING YOUR DAILY ACTIVITIES ARE YOU EXPOSED TO THESE AS WELL? YES NO
- WHAT HOBBIES DO YOU HAVE?

ALLERGY & ASTHMA CENTER OF THE ROCKIES

PRE SKIN TEST INSTRUCTIONS

Please read these directions carefully before coming in for your skin test appointment. Prepare to be in the office for several hours that day. Over the counter and prescription drugs may affect skin testing including antihistamines containing cold and allergy medications and sleep aids, histamine blockers and some antidepressants. Allergy testing is performed by scratching liquid antigens onto the patient's back, then allowing 15 minutes for a reaction to occur. This reaction is a mosquito-like bump that varies in size and redness. The size of the reaction determines if further testing is required. A small amount of allergen is injected into the arms of those that did not show reactions on the back. The size of the reactions helps the physician to determine the patient's allergies and level of sensitivity, which will be discussed after all the testing is completed.

DISCONTINUE -

SHORT ACTING ANTIHISTAMINES -5 DAYS PRIOR TO TESTING:

Azatadine (Optimine, Trinalin)
Brompheniramine (Bromfed, Bromphen, Cophene-B, Dallergy-JR, Dimetapp Allergy Liqui-Gels, Lordane products, Nasahist B, Poly-Histine products, Rondec products, Ultrabrom products)
Chlorpheniramine (Aller-Chlor, Atrohist products, Chlor-Trimeton, Duravent DA, Extendryl, Kronofed, Nolamine, Ornade Spansule, Pediacare Allergy Formula, Respar-A.R.M., Sudafed Cold and Allergy, Sinutab Sinus Allergy, Teldrin, Tylenol Cold and Allergy products)
Clemastine (Contac 12 Hour Allergy, Tavist products)
Cyproheptadine (Periactin)
Dexchlorpheniramine (Dexchlor, Polaramine)
Dimenhydrinate (Calm X, Dinate, Dramamine, Dramanate, Hydrate, Triptone Caplets)
Diphenhydramine (**Benadryl**, AllerMax Caplets, Compoz, Diphen Cough, Diphenhist, Dormarex 2, Genahist, Hyrexin, Nervine Nighttime Sleep-Aid, Nytol, Siladryl, Sleep-Eze D, Sominex, Twilite Caplets, Tylenol Cold and Allergy products, Unisom SleepGels Maximum Strength)
Doxylamine (Tylenol Flu Nighttime, Unisom Nighttime Sleep Aid)
Phenindamine (Nolahist, Nolamine, Poly-Histine products, Triaminic products)
Tripelennamine (PBZ, PBZ-SR, Pelamine)
Hydroxyzine (Atarax, Vistaril)
ANY NIGHT TIME MEDICATIONS: Tylenol pm, Excedrin pm

LONG ACTING ANTIHISTAMINES FOR 7 DAYS PRIOR TO TESTING:

Allegra, **Fexofenadine** products (5 days)
Astelin nasal spray (7 days)
Astepro nasal spray (7 days)
Claritin/Clarinex, **Loratadine** products (5 days)
Zyrtec, **Cetirizine** products (7 days)
Xyzal, Levocetirizine products (7 days)
Alavert products (7 days)
Patanase nasal spray (7days)
Singulair products (7days)
Zyflo products (7days)
ALL ALLERGY EYE DROPS
HOMEOPATHIC ALLERGY FORMULAS

DISCONTINUE –ACID REFLUX MEDICAITONS

Acid reflux/stomach drugs (histamine blockers) 48 HOURS PRIOR TO TESTING:
Nizatidine (Axid), **Famotidine** (Pepcid), **Ranitidine** (Zantac), **Cimetidine** (Tagamet)

DISCONTINUE ONLY IF OKAYED BY PRESCIBING DOCTOR **Other drugs including certain antidepressants and anti-anxiety agents for 7 DAYS PRIOR TO TESTING:**

Amitriptylene
Amoxapine
Maprotinine
Desipramine
Doxepin (Sinequan)
Hydroxyzine (Atarax, Vistaril)
Imipramine (Tofranil)
Xanax
Nortriptyline
Protriptylene (Vivactil)
Trazadone
Trimipramine (Surmontil) **Clomipramine**
Seroquel

DO NOT DISCONTINUE **COMMON SSRI ANTIDEPRESSANTS - CELEXA, PROZAC, PAXIL AND ZOLOFT**

STEROIDS- NEVER STOP STEROIDS WITHOUT ASKING YOUR PRESCIBING DOCTOR. WHEN TAKING ORALLY, AS AN INJECTION OR IV, IT MAY REDUCE YOUR ALLERGY SKIN TEST RESPONSE, SO PLEASE CALL TO CONFIRM WHETHTER YOUR DOSE IS ACCEPTABLE. INHALED STEROIDS ALWAYS CONTINUE.

HIPAA FORM

CONSENT

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by AAACOR for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of AAACOR. I understand that diagnosis or treatment of me by AAACOR may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. AAACOR is not required to agree to the restrictions that I may request. However, if AAACOR agrees to a restriction that I request, the restriction is binding on AAACOR and William A. Lanting MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that AAACOR has taken action in dependence on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review AAACOR, Notice of Privacy Policies prior to signing this document. The AAACOR, Notice of Privacy Policies has been provided to me. The Notice of Privacy Policies describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the AAACOR. The Notice of Privacy Policies for AAACOR is also provided at 1029 Robertson st. Fort Collins, CO 80524 or 8223 W. 20th st. Suite B, Greeley, CO 80634. This Notice of Privacy Policy also describes my rights and the AAACOR's duties with respect to my protected health information.

AAACOR reserves the right to change the privacy policies that are described in the Notice of Privacy Policy. I may call the office and request a revised copy be sent to me in the mail or by asking for one at the time of my next appointment.

I, ________________________________, give permission to let the AAACOR staff leave medical information in a message on my voice mail. Please list phone number:___________________________

[ ] I give AAACOR permission to take my photo for my medical chart

Signature of Patient or Guardian x____	If patient is a CHILD, please list other contacts that can accompany your child, or to whom medical information can be disclosed. If you as an ADULT would like to give permission to anyone to be allowed to discuss your medical information, list them here:
Date:	Name & Relation to Patient:

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Email Address: (for current medical information, newsletters, and patient communication)	1. Phone:
Printed Name of Patient or Guardian: x____	2. Phone:

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