Welcome to our practice!

- Please complete the enclosed questionnaire and mail, fax, or email it back to us **1 week** prior to your appointment.

- Obtain a copy of your medical record if you have been previously evaluated by an allergist.

- If indicated, skin testing can be performed on your initial visit. **For this test to be valid, you should not take any medications containing antihistamines, including antihistamine eye drops, for a period of (7) seven days prior to the appointment and muscle relaxants for 2 weeks prior** . Please refer to the list on the back of this page. Tricyclic antidepressants also interfere with skin testing: these include Elavil (amitriptyline), Pamelor (nortriptyline), and Doxepin (sinequan). Abruptly stopping these medications may cause side effects, so call for specific instructions if you are on a tricyclic antidepressant. **Medications that you may be taking for other medical problems such as high blood pressure, diabetes, asthma, etc. should be continued as usual**. If you are uncertain about which medications you need to stop prior to this appointment, please telephone to inquire further.

- Patients coming in for evaluation of hives (itchy, red rash) may continue to take their antihistamines.

- Your evaluation may include skin testing, breathing tests and other specialized procedures in addition to your initial consult. Due to the expense involved, and the fact that some insurance plans do not provide coverage, we strongly suggest you contact your health insurance company to verify your plan covers allergy evaluations. You will be responsible for any charges your health insurance company does not cover.

- Our policy requires all co-pays be paid at check-in on the day of service for all office visits.

- Minors (up to 18 years of age) must be accompanied by a parent or guardian.

- Most initial appointments will take up to two (2) hours.

- For consideration of our patients and staff, we request you do NOT wear perfumes, colognes, and fragrant body lotions. Some of our patients have severe adverse reactions to these scents. Thank you for your understanding

- Please feel free to call us if you have any questions regarding the above, or if we can help clarify anything else prior to your appointment. Thank you for your cooperation.

Park Allergy Center

Drugs that block allergy skin tests

Allergy Eye Drops - 1 weeks prior : Such as Patanol, Zaditor, generic Ketotifen
Allergy Eye Drops - 4 weeks prior : Optivar

Muscle Relaxants - 2 weeks prior: Such as Flexeril/cyclobenzaprine

Antihistamines - 7 days prior:
Actifed Cold and Allergy
Alavert
Allegra, Allegra-D 12 hour, Allegra-D 24 Hour
Astelin - **Must stop 4 weeks prior to testing**
Astepro - **Must stop 4 weeks prior to testing**
Atarax
Benadryl
Bromfed, Bromfed-DM, Bromfed-PD
brompheniramine
cetirizine
Clarinex, Clarinex Reditabs, Clarinex-D 12 Hour, Clarinex-D 24 Hour
Claritin, Claritin Reditabs, Claritin-D 12 Hour, Claritin-D 24 Hour
Chlor-Trimeton
chlorpheniramine, chlorpheniramine/pseudoephdrine
clemastine fumarate
cyprohepatadine
Deconamine SR
Dimetapp, Dimetapp Cold & Allergy Elixir
diphenhydramine
fexofenadine
hydroxyzine
Ibuprofen Cold & Allergy
loratadine, loratadine/pseudoephedrine
Motrin Cold & Allergy
Palgic
Patanase - **Must stop for 4 weeks prior**
pseudoephdrince/triprolidine
Rondec DM Drops, Rondec DM Syrup, Rondec Drops, Rondec Syrup
Semprex-D
Tavist Allergy
Tussionex PennKinetic
Tylenol Cold & Allergy
Vistaril
Xyzal
Zyrtec
This is not an all inclusive list. Please call our office if you have any questions.

Welcome To Park Allergy Center
2017 PATIENT INFORMATION

PLEASE NOTE: If you are covered under your parent's, step-parent's or spouse's insurance no matter patient's age we must have your spouse's or parent's information to file insurance claims

Last Name:_____First Name:_____ Middle Initial:____

Nickname:_____ Male _____ Female _____ SS#:_____-_____-_____

Street Address:_____ City: _____State: _____Zip:_____

Birthdate _____Age_____ Marital: single married widowed divorced Email:_____

Home Phone:_____ Cell:_____ Circle which phone to leave messages: Home Cell Work

Employer: _____Occupation: _____Work Phone:_____

Primary Physician:_____Referring Physician:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Spouse Information

Spouse:_____ Birthdate _____SS#_____-_____-_____

Employer:_____Phone#'s: Home:_____ Cell:_____Work:_____

******Parent information - All patients under 18 must have both parent's information filled out********

Father:_____Birthdate:_____SS#_____-_____-_____ Married Single Divorced

Street Address:_____ City: _____State: _____Zip:_____

Employer:_____Phone#'s: Home:_____ Cell:_____Work:_____

Mother:_____Birthdate:_____SS#_____-_____-_____ Married Single Divorced

Street Address:_____ City: _____State: _____Zip:_____

Employer: _____Phone#'s: Home:_____ Cell:_____Work:_____

Please fill out step-parent's information if needed for insurance or contact information

Step-Parent:_____Birthdate: _____SS#_____-_____-_____ Is married to Father or Mother

Street Address:_____ City: _____State: _____Zip:_____

Employer: _____Phone#'s: Home:_____ Cell:_____Work:_____

Primary Insurance: Who supplies your Primary Insurance (please check one)

O My employer O Spouse's employer O Father's employer O Mother's employer O Step-Parent's employer O Self Insured

Primary Insurance:_____ Subscriber ID#:_____ Group#:_____

Do you have secondary insurance? Please circle Yes or No If yes, Who supplies your Secondary Insurance (please check)

O My employer O Spouse's employer O Father's employer O Mother's employer O Step-Parent's employer O Self Insured

Secondary Insurance:_____ Subscriber ID#:_____ Group#:_____

I hereby authorize Park Allergy Center, PC to examine and treat me or my child and to perform such diagnostic tests as may be necessary for the duration of this illness. I hereby authorize the release of any medical information necessary to process my insurance claims. I understand the medical information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental disorders and or HIV serostatus. I hereby authorize for any benefits payable under my policy be paid directly to Park Allergy Center. Unless you specifically request a refund of any credit balance, all refunds and overpayments less than $25 will be applied as a credit on the patient's account and will be treated as unclaimed property under Michigan law if not used within three (3) years. All other credit balances will be refunded to you.

I understand that I am ultimately responsible for all charges, copays, deductibles, co-insurance and remaining balances not paid or covered by my insurance.

Signature of PATIENT (or Guardian):_____Date_____

Guardian's Printed Name:_____ Relationship to Patient:_____

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Allergy Center

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Questionnaire can be filled out and submitted online at parkallergy.com – Forms – Online Questionnaire

TO BE RETURNED 1 WEEK PRIOR TO APPOINTMENT

Park Allergy Center, PC

Michael Park, MD
Lucetta Lyford, PA-C

430 W Centre Ave
Portage, MI 49024

Phone: (269)321-6673
Fax: (269)324-5594

ALLERGY/ASTHMA QUESTIONNAIRE

How did you hear about us: (circle) Physician Referral Family/Friend Website Phonebook Other_____

Name:_____ Age:_____ Appointment Date:_____

Birthdate:_____ Occupation/Place of Work:_____

Please Circle: African American Asian Caucasian Hispanic Other: _____

Describe the problem(s) you have been experiencing:_____

_____

_____

Length of time you have had the problem(s):_____

If you have been away from home in the past year, were symptoms better or worse while there? (Circle) Better Worse No Difference

Which season(s) bother your symptoms the most? (Circle)
All the time Spring Summer Fall Winter Changes of seasons

Previously evaluated by an allergist? (circle) Yes No **If yes, who and when:**_____

_____

Were skin test performed? (circle) Yes No **If yes, what were the results:**_____

_____

Have you ever received allergy shots before? (circle) Yes No **If yes, when did you start and end your treatment?**_____

If yes, did you feel allergy shots were helpful? (circle) Yes No

ALLERGY HISTORY

Do you live in a (circle): House Apartment Condo Dorm Mobile Home Other_____

Age of dwelling/Year built:_____ **Length of Occupancy:**_____

Mattress (circle): Conventional Water Air Other _____**How old?** _____

Pillow (circle): Feather Foam Dacron/Polyester Other_____ **How old?**_____

Pets (circle and indicate how many): Cat_____Dog_____Other furry pets_____

Ever been stung by a bee, wasp, hornet? (circle) Yes No I**f yes, describe the reaction** _____

Ever had poison ivy/oak/sumac? (circle) Yes No **Stuffy nose that worsens at night (circle)?** Yes No

Adverse reaction to medications (specify name/reaction):_____

Adverse reaction to foods (specify food/reaction):_____

Adverse reaction to latex or rubber:_____

Adverse reaction to previous immunizations:_____

Current medications:_____

_____

Past and current medical problems:_____

_____

Past surgeries:_____

SOCIAL HISTORY

Who lives with you in your home (circle): Live alone Roommate Significant other/Spouse Siblings Parents

Does anyone in your home smoke: Yes No

Patient's smoking status (circle): Current Former Never

Alcohol use (circle): Daily Weekly Monthly Yearly Never

Children (circle): Yes No **If yes, how many boys?** _____ **girls?**_____

FAMILY HISTORY

Parents (circle): Seasonal/Animal Food allergies Asthma Eczema Other_____

Siblings (circle): Seasonal/Animal Food allergies Asthma Eczema Other_____

Children (circle): Seasonal/Animal Food allergies Asthma Eczema Other_____

REVIEW OF SYSTEMS Circle and describe any other problems not mentioned above

Eyes	Muscles/bones/joints	
Ear/Nose/Throat	Skin	_____
Heart	Neurological	
Lungs	Psychiatric	_____
Gastrointestinal	Hormonal	
Genital/bladder/kidney	Blood/lymphatic	_____

Park Allergy Center, PC

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

_____

We will not retaliate against you for filing a complaint.

Effective Date 01/01/2017 Publication Date 01/01/2017

Park Allergy Center, PC
Form Number HF001a

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____
Name of patient

_____
Signature of patient or personal representative

_____
If signed by personal representative, relationship to patient

_____
Date

I further authorize the following person(s) to make the request for the use or disclosure of my Medical Information (PHI) on my behalf:

□ Myself □ Spouse:_____ □ Parent(s):_____

□ Child(ren):_____ □ Other:_____

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

. □ Refused to Sign □ Physically unable to sign
(Other)_____
_____
_____

Employee Signature:_____ Date:_____

Park
Allergy Center

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Park Allergy Center

ATTENTION: PATIENTS AND PARENTS

Our office requires social security numbers for our patients based on the fact we are extending credit to our patients with participating insurance.

In order to offer the courtesy of billing your insurance, rather than payment at the time of service, we must have your social security number. If you do not wish to provide your social security number, you will be required to pay the balance of all services rendered on the day of service. Once your insurance company has provided payment we will make a refund to you of any credit balance.

ATTENTION: PATIENTS AND PARENTS

EFFECTIVE OCTOBER 16, 2003

NEW GOVERNMENT REGULATIONS went in to effect regarding the submission of insurance claims. This is another facet of HIPAA (The Health Information Portability & Accountability Act).

These regulations require that we submit claims with more information than what has been required in the past. We will need the policyholder's date of birth for your insurance coverage.

WE CAN NOT FILE YOUR INSURANCE CLAIM WITHOUT THIS INFORMATION – YOUR INSURANCE COMPANY WILL NOT ACCEPT OUR CLAIM UNLESS IT IS COMPLETE..

If you can not provide this information, you will be responsible for payment of all services rendered at your visit and you will need to file for insurance benefits on your own.

If you have any questions regarding these policies, our staff will be happy to help

Park
Allergy Center

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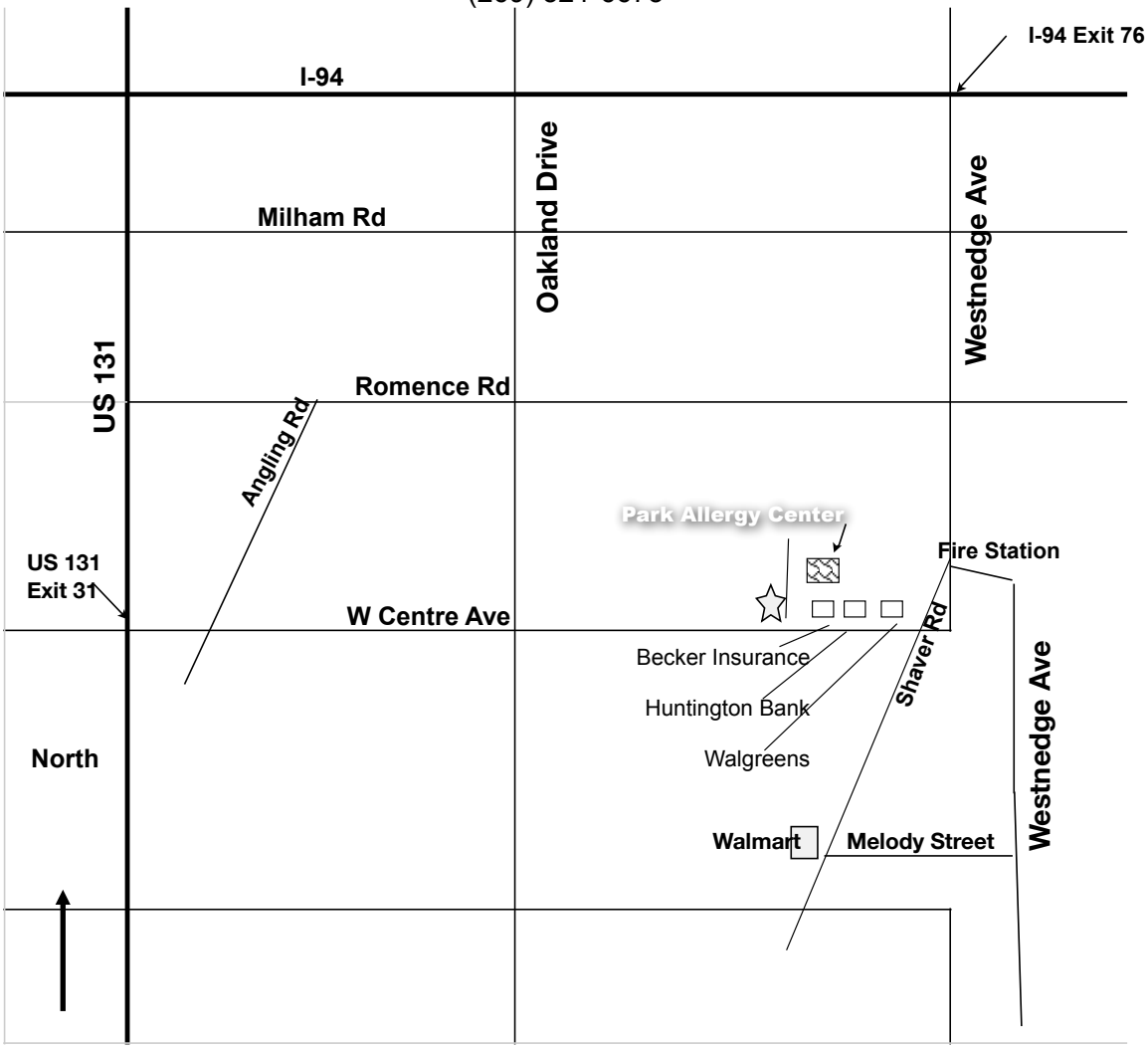
Park Allergy Center
430 West Centre Ave
Portage, MI 49024
(269) 321-6673



The office is located in Portage Creek Landing Office Park (gray sign on Centre). We are directly behind 420 W. Centre Ave, Becker Insurance, which is located on Centre Ave. The office park is on the same side of the street as Walgreens Pharmacy.

Directions:

From the North (via US-131 S)

1. Take exit 31, Centre Ave toward Portage	
2. Turn Left onto W Centre Ave	2.8 miles
3. Turn Left into Portage Creek Landing	
4. Turn Right into Park Allergy Center	

From South US-131 N

1. Turn Right onto Shaver Road	4.6 miles
2. Turn Left onto W Centre Ave	.1 mile
3. Turn Right into Portage Creek Landing	
4. Turn Right into Park Allergy Center	

From the West (via I-94 E)

1. Take exit 76, S. Westnedge Ave	
2. Turn Right onto S. Westnedge	2.3 miles
3. Keep straight on Shaver Ave	.2 miles
4. Turn Right onto W. Centre Ave	
5. Turn Right into Portage Creek Landing	
6. Turn Right into Park Allergy Center	

From the East (via I-94 W)

1. Take exit 76, S Westnedge Ave	
2. Turn left onto S Westnedge Ave	2.4 miles
3. Keep straight onto Shaver Road	.2 miles
4. Turn Right onto W Centre Ave	.1 miles
5. Turn Right into Portage Creek Landing	
6. Turn Right into Park Allergy Center	