

Patient Information

Legal Last Name: _____ Legal First Name: _____ M.I.: _____
 Preferred Name: _____ Birth Date: ____/____/____ Gender: M F Other
 Social Security #: _____ or Driver's License #: _____
 Race: Caucasian African American Asian Other _____ Ethnicity: Hispanic/Latino Non Hispanic/Latino
 Marital Status: Married Single Divorced Other _____ Preferred Language: English Other _____
 Address: _____
Street City State Zip
 Home Phone: _____ Work #: _____ Cell Phone: _____
 Email: _____ Preferred contact number for results and messages (circle one): Home Work Cell
 Preferred communication method for appointment reminders/notification (circle one): Phone Call (primary #) Text Email Portal Message
 Primary Physician: _____ Phone Number: _____
 Referring Physician: _____ Phone Number: _____
 Preferred Local Pharmacy (name & major cross streets): _____ Phone Number: _____
 Mail Order Pharmacy (if used): _____ Phone Number: _____
 How did you hear about us? Review Site Internet Search Social Media TV Ad/Ad in Clinic Referral from family, friend, etc.
 Referral from doctor Insurance website Previous Patient Other _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Responsible Party

If same as above, leave blank. If different, please complete all sections.

Legal Last Name: _____ Legal First Name: _____ M.I.: _____
 Address: _____
Street City State Zip
 Home Phone: _____ Cell Phone: _____ Email: _____
 Birth Date: ____/____/____ Gender: M F Other
 Social Security #: _____ or Driver's License #: _____

Please complete and provide us a copy of the insurance cards.

Insurance Information

Primary Insurance Company: _____
 Address: _____
Street City State Zip
 ID Number: _____ Group Number: _____
 Insured Name: _____ Insured DOB: _____
 Insured Employer: _____ Relationship to Patient: _____
Secondary Insurance Company: _____
 Address: _____
Street City State Zip
 ID Number: _____ Group Number: _____
 Insured Name: _____ Insured DOB: _____
 Insured Employer: _____ Relationship to Patient: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Boulder Valley Asthma and Allergy Clinics, PC. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize BVAAC and/or my insurance company to release any and all information required to process my claims.

Patient/Responsible Party Signature _____ **Date** _____



BOULDER VALLEY ASTHMA AND ALLERGY

Financial Policy

Thank you for choosing Boulder Valley Asthma and Allergy Clinics, PC (BVAAC) for your allergy, asthma and immunology healthcare needs. We are committed to providing the very best medical care. We do our best to inform you of any allergy benefit information that we receive from your insurance carrier; however, it is ultimately your responsibility to pay for any charges you incur. The following is a statement of our Financial Policy, which you must read, agree to and sign prior to treatment. *If you have questions or concerns, please contact our billing office at 303-234-1067 opt. 3 prior to your appointment.*

- Know your insurance coverage, benefits and referral requirements: there are many insurance companies, all with several different plans, policies and benefits. **It is your responsibility to be aware of and understand your insurance benefits, coverage, exclusions, deductibles, co-insurance and referral requirements.**
- BVAAC accepts most major insurance plans; however, there may be plans which we are excluded from participating in. We recommend calling your insurance company to verify that we are in-network providers prior to your appointment. It is your responsibility to verify that BVAAC is a participating provider on your specific plan.
- We will bill your insurance company for your office visits, testing, allergy extracts, injections, etc. However, at the time of your appointment it is your responsibility to pay:
 - Any insurance copayment amount (as listed on your card). We are a specialist and charge the specialist copay.
 - Any amount subject to your deductible or co-insurance.
 - Any amount not covered by your insurance coverage.
- Failure to collect this amount at the time of service does not change your financial responsibility.
- Patients/Guardians are financially responsible for all charges, regardless of third-party guarantors.
 - In the case of a divorce situation, the adult accompanying the minor child is responsible for payment of services. Our office staff will not participate in any disputes, which may arise with respect to financial liability due to legal custody agreements.
- Self-pay patients must pay in full at the time of service, unless a satisfactory payment arrangement has been made with our billing office, prior to services being rendered.
- Any account balance is expected to be paid in full prior to new services being rendered.
- We accept cash, checks, Visa, Mastercard, and Discover. Payment may be made through our patient portal, over the phone by calling 303-234-1067 opt. 3, or by mail.
- Should it be necessary for BVAAC to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/or attorney fees.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes (name, address, phone number, insurance coverage, etc.), you must inform this practice as soon as possible. Insurance denials or billing errors due to patient supplied information will result in the transfer of account balances to the patient's immediate financial responsibility.

Appointment Cancellation/No Show Policy/Tardy Policy

Boulder Valley Asthma and Allergy Clinics, PC (BVAAC) understands that there are times when you must miss an appointment due to an emergency or unforeseen circumstances. However, when you do not call to cancel your appointment, you may be preventing another patient from receiving much needed medical care. If you need to cancel your appointment to see a BVAAC physician, you must do so within 24 hours of the appointment or you will be charged a \$50 cancellation fee. This fee will not be covered by your insurance. You need to speak directly with a BVAAC staff member to cancel an appointment and avoid the late cancellation charge.

We understand that delays can happen; however, we must try to keep other patients and physicians on time. If a patient arrives 15 minutes past their scheduled check in time, we will have to reschedule the appointment.

My signature below indicates that I have read and agree to BVAAC financial policy, appointment cancellation, no show and tardy policies. I understand that I am financially responsible for all charges. I understand that it is my responsibility to contact the office to reschedule and/or cancel my appointment.

Patient/Responsible Party Signature: _____ Date: _____

Patient Name (printed): _____ Date of Birth: _____



BOULDER VALLEY ASTHMA AND ALLERGY

Acct # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Boulder Valley Asthma and Allergy Clinics, PC (BVAAC) to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available on our website www.denverallergy.com or it is available in our offices.

I give permission for BVAAC to contact me in the following ways. BVAAC is allowed to leave messages as indicated below. A detailed message could outline results, answer questions, give details about treatment, payments, and/or appointment reasons, etc. A short message would ask for a call back only. (You may check more than one box)

Cell Phone: _____ Detailed Message Short Message With Whomever Answers No Message

Land Line: _____ Detailed Message Short Message With Whomever Answers No Message

Work Line: _____ Detailed Message Short Message With Whomever Answers No Message

Email Address: _____

I give permission for BVAAC to communicate with the following individuals regarding my care (list as many or few as you wish):

Name: _____ Phone: _____ Relationship: _____
 Medical Information (test results, treatment, etc.) Financial Information (billing, patient balance, etc.)

Name: _____ Phone: _____ Relationship: _____
 Medical Information (test results, treatment, etc.) Financial Information (billing, patient balance, etc.)

Name: _____ Phone: _____ Relationship: _____
 Medical Information (test results, treatment, etc.) Financial Information (billing, patient balance, etc.)

I do not give permission for BVAAC to communicate with anyone else regarding my care: _____ (initial)

The physicians at Boulder Valley Asthma and Allergy Clinics, PC, participate in pharmaceutical/medical research studies. We believe that this is a valuable service as it not only allows us the ability to evaluate potentially new therapies for our patients, but also provides us with the opportunity to remain current in our chosen field of medical science. A study/research coordinator will be allowed to review my PHI to determine if I am a potential candidate for participation. The study/research coordinator will NOT release my name or other personal information other than that which directly pertains to the pharmaceutical/medical research study to any third party or outside agencies.

Yes No

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

Patient/Responsible Party Signature: _____ Date: _____

Patient Name (printed): _____ Date of Birth: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Additionally, I hereby acknowledge that I have received a copy of Boulder Valley Asthma and Allergy Clinics' Notice of Privacy Practices. This is available on our website www.denverallergy.com or may be requested in our office. I understand that I have the right to refuse to sign this acknowledgement, if I so choose.

Patient/Responsible Party Signature: _____ Date: _____

Patient Name (printed): _____ Date of Birth: _____

Office Use Only: Reason acknowledgement could not be attained on _____ (date)

Refused to Sign Emergency Situation Communication Barrier Other: _____



BOULDER VALLEY ASTHMA AND ALLERGY

ACCT# _____

All New Patients Need to Complete This Page

NAME: _____

DATE: _____

Reason for appointment _____

INFORMANT: Patient Parent Other _____

Have you had any previous allergy evaluations? Yes No

CURRENT OR RECURRENT SYMPTOMS (please check all boxes that apply):

CONSTITUTIONAL Fatigue Fever Sweats Weight Gain Weight Loss Poor Appetite

EYES Itching Redness Watering Dryness Other

EARS Pain Plugged Itching Ringing Recurrent Infections PE Tubes Other

NOSE/SINUSES/THROAT Runny Nose Postnasal Discharge Stuffiness Sneezing Nose Bleeds Nasal Polyps
 Loss of Smell/Taste Snoring Sinus Pressure/Headache Sore Throat Itchy Throat
 Hoarseness Frequent Throat Clearing

CARDIOVASCULAR Chest Pain Fast or Irregular Heart Rate Fainting Swelling of Ankles/Feet Heart Murmur Other

RESPIRATORY Productive Cough Dry Cough Wheezing Chest Tightness Shortness of Breath
 Coughing or Wheezing with Exercise

GASTROINTESTINAL/DIGESTIVE Bloating Abdominal Pain Constipation Diarrhea Vomiting Heartburn
 Difficulty Swallowing

GENITOURINARY Frequent Urinary/Bladder Infections Other

For Women: Currently Pregnant Menopausal

For Men: Prostate Problems

SKIN Itching Eczema Hives Psoriasis Other Rash

NEUROLOGIC Headaches Seizures Sleep Disturbance Other

MUSCULOSKELETAL Joint Swelling Joint Pain Muscular Pain Back Pain Other

ENDOCRINE Cold Intolerance Unusual Hair Loss Excessive Thirst Unexplained Weight Change Other

PSYCHIATRIC Depression Anxiety Mood Disorder Other

BLOOD/LYMPH Lymph Node Swelling Anemia Other

ALLERGY/IMMUNOLOGY Allergy Swelling/Angioedema/Anaphylaxis Frequent Bronchitis/Pneumonia Frequent Sinusitis

ADDITIONAL NOTES/SYMPTOMS:

ENVIRONMENTAL HISTORY:

Heating System: Forced Air Hot Water Baseboard Other

Air Conditioning: None Central Window//Wall AC Evaporative Cooler

Home: House Townhouse Condo Apartment Mobile Home

Years in Current Home: _____ Age of Home _____

Years lived in Colorado: _____ Native

Down/Feather Bedding: None Pillows Comforter Mattress Topper

Mattress: Spring Foam/Latex Air/Water Age of mattress _____

Flooring: Main Living Area Carpet Wood/Tile

Bedroom Carpet Wood/Tile

Basement Cement Sub floor Unfinished Carpet Wood/Tile etc. Crawl Space

Wool Carpeting/Area Rugs Yes No

Other Occupational or Home Exposures:



BOULDER VALLEY ASTHMA AND ALLERGY

ACCT # _____

COMPLETE THIS PAGE ONLY IF NOT DONE ON PATIENT PORTAL

NAME: _____

DATE: _____

FAMILY HISTORY:

	Nasal Allergy	Asthma	Food Allergy	Skin Allergy	Other Conditions
Mother					
<input type="checkbox"/> Living <input type="checkbox"/> Deceased					
Father					
<input type="checkbox"/> Living <input type="checkbox"/> Deceased					
Brother #Living ____					
#Deceased ____					
Sister #Living ____					
#Deceased ____					
Grandmother (Maternal)					
<input type="checkbox"/> Living <input type="checkbox"/> Deceased					
Grandmother (Paternal)					
<input type="checkbox"/> Living <input type="checkbox"/> Deceased					
Grandfather (Maternal)					
<input type="checkbox"/> Living <input type="checkbox"/> Deceased					
Grandfather (Paternal)					
<input type="checkbox"/> Living <input type="checkbox"/> Deceased					
Aunt					
<input type="checkbox"/> Living <input type="checkbox"/> Deceased					
Uncle					
<input type="checkbox"/> Living <input type="checkbox"/> Deceased					

Dogs	Yes <input type="checkbox"/> # _____ No <input type="checkbox"/>
Cats	Yes <input type="checkbox"/> # _____ No <input type="checkbox"/>
Other	Describe: _____

TOBACCO/SUBSTANCE USE: (complete if age 13 or over)

Cigarettes	Never <input type="checkbox"/> Former <input type="checkbox"/> Age started ____ Age Stopped ____ Average # cigs per day ____ Current <input type="checkbox"/> Age started ____ Average # cigs per day ____
Other Tobacco	Describe: _____
Vaping/E-cigarettes	Do you vape and/or use e-cigarettes? Yes <input type="checkbox"/> No <input type="checkbox"/> How often? _____ What do you vape? _____
Daily Second-Hand Smoke Exposure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alcohol Use	None <input type="checkbox"/> Former <input type="checkbox"/> Current <input type="checkbox"/> Average # of Drinks per day ____ per week ____ Only occasional <input type="checkbox"/>
Marijuana Use	None <input type="checkbox"/> Daily <input type="checkbox"/> Occasional <input type="checkbox"/>
Other Substance Use	Describe: _____

ADDITIONAL NOTES:



Medications to Hold

- Actifed
- Adapin (Doxepin)
- Alavert (All Types)
- Allegra (Fexofenadine)
- Amitriptyline (Elavil)
- Anafranil (Clomipramine)
- Antihistamines (all types)
- Antivert (Meclizine)
- Astelin
- Asendin (Amoxampine)
- Atarax (Hydroxyzine)
- Atrohist
- Aventyl (Nortriptyline)
- Axid (Nizatidine)
- Benadryl (Diphenhydramine)
- Brompheniramine (Bromfen)
- Cetirizine
- Chlorpheniramine (Ornade)
- Chlorpromazine (Thorazine)
- Chlortrimaton (Chlorpheniramine)
- Cimitidine (Tagamet)
- Claritin (Loratadine)
- Clarinex (Desloratidine)
- Clemastine (Tavist)
- Clomipramine (Anafranil)
- Compazine (Phenothiazine)
- Cyproheptadine (Peri actin)
- D'Allergy
- Deconamine
- Dimetapp
- Diphenhydramine (Benadryl)
- Desipramine (Norpramin)
- Doxepin (Adapin, Sinequan, Zonalon)
- Dramamine
- Drixoral
- Elavil (Amitriptyline)
- Famotidine (Pepcid)
- Fexofenadine (Allegra)
- Histussin
- Hydroxyzine (Atarax, Vistanil)
- Imipramine (Tofranil)
- Loratadine
- Meclizine (Anti vert)
- Nizatidine (Axid)
- Norpramin (Desipramine)
- Nortriptyline (Pamelor,)
- Nova fed
- Nyquil
- Optimine (Azatadine)
- Pamelor (Nortriptyline)
- Periactin (Cyproheptadine)
- Pepcid (Famotidine)
- Phenergan (Promethazine)
- Prochlorperazine (Compazine)
- Ranitidine (Zantac)
- Rondec
- Rynatan
- Semprex
- Sinequan (Doxepin)
- Surmontil (Trimipramine)
- Tagamet (Cimitidine)
- Tavist (Clemastine)
- Tofranil (Imipramine)
- Triaminic
- Tylenol Allergy, Cold & Flu Products
- Tussionex
- Xyzal (levocetirizine)
- Zantac (Ranitidine)
- Zonalon (Doxepin)
- Zyrtec