BOULDER VALLEY ASTHMA AND ALLERGY

Acct # _____

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 #: _____

Insurance Information

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

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:** _____

CHRONIC OR PAST MEDICAL PROBLEMS: None ☐

□ ***Asthma***	□ GERD	□ Osteoporosis
□ AIDS	□ Glaucoma	□ Other Autoimmune Disease
□ ***Angioedema/Anaphylaxis***	□ ***Hay Fever, Nasal Allergies***	□ Other Heart Disease
□ Barrett's Esophagitis	□ Hepatitis (Type if known)	□ Other Liver Disease
□ Blood Clotting Disorder	□ High Blood Pressure	□ Other Lung Disease
□ Cancer – Type:	□ High Cholesterol and/or Triglycerides	□ Psoriasis
□ Cataracts	□ ***Hives***	□ Rheumatoid Arthritis
□ COPD	□ ***Immunodeficiency***	□ Sarcoidosis
□ Crohn's Disease	□ Insect Sting Allergy	□ Seizures/Epilepsy
□ Diabetes - Type 1 Type 2	□ Kidney Disease	□ ***Sinus Problems***
□ ***Eczema***	□ Latex Allergy	□ Stroke
□ Emphysema	□ Lupus	□ Thyroid Disease
□ Eosinophilic Esophagitis	□ Migraine Headaches	□ Ulcerative Colitis
□ ***Food Allergy***	□ Osteoarthritis	
List Any Other Serious or Chronic Medical Problems: □None		

PAST SURGERIES/HOSPITALIZATIONS except for normal births**:** (include year) NONE ☐

□ Adenoidectomy	**Other Surgeries:**
□ Nasal/Sinus Surgery	
□ PE Tubes	
□ Tonsillectomy	

CURRENT MEDICATIONS: (include dosage and frequency)

Prescription (include dose and frequency)	Over the Counter/Vitamins/Supplements
Drug Allergies/Adverse Reactions:	

Continue to back of page →

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 □Living □ Deceased					
Father □Living □ Deceased					
Brother #Living ____ #Deceased ____					
Sister #Living ____ #Deceased ____					
Grandmother (Maternal) □Living □ Deceased					
Grandmother (Paternal) □Living □ Deceased					
Grandfather (Maternal) □Living □ Deceased					
Grandfather (Paternal) □Living □ Deceased					
Aunt □Living □ Deceased					
Uncle □Living □ Deceased					

Dogs	**Yes □ #_____ No □**
Cats	**Yes □ #_____ No □**
Other	**Describe:**

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

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

ADDITIONAL NOTES:

Medications to Hold

FOR 72 HOURS (3 DAYS) PRIOR TO YOUR SCHEDULED APPOINTMENT

- 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 (Cyproheptadi e)
- Pepcid (Famotidine)
- Phenergan (Promethazi e)
- 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