

# BOULDER VALLEY ASTHMA AND ALLERGY

## PATIENT INFORMATION

Account No: \_\_\_\_\_

Prefix: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name: \_\_\_\_\_ Suffix : \_\_\_\_\_ Gender: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Previous Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Work Phone:(\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Communication Method of Contact for (Check all that apply)

Appointment Reminders      Notifications      Test Results

Home      Cell      Work      Email

Ok to Leave Voicemail?

Date of Last Appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_ or New Patient (Check)

## Responsible Party (If Same as above, leave blank)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_

Preferred Communication Method of Contact for (Check all that apply)

Appointment Reminders      Notifications      Test Results

Home      Cell      Work      Email

Ok to Leave Voicemail?

## Emergency Contact Information

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relation: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Marital Status: \_\_\_\_\_  
Preferred Language: \_\_\_\_\_  
Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

## Insurance

Primary Insurance Company \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insured Employer: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
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 Signiture \_\_\_\_\_ Date: \_\_\_\_\_

# BOULDER VALLEY ASTHMA AND ALLERGY

## AUTHORIZATION FOR RELEASE OF INFORMATION

Acct# \_\_\_\_\_

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

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](http://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: \_\_\_\_\_

Land Line: \_\_\_\_\_

Work Line: \_\_\_\_\_

Email Address: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Medical Information (test results, treatment, etc.)                      Financial Information (Billing, Patient Balances, etc.)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Medical Information (test results, treatment, etc.)                      Financial Information (Billing, Patient Balances, etc.)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Medical Information (test results, treatment, etc.)                      Financial Information (Billing, Patient Balances, etc.)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Medical Information (test results, treatment, etc.)                      Financial Information (Billing, Patient Balances, etc.)

**BOULDER VALLEY ASTHMA AND ALLERGY**  
**AUTHORIZATION FOR RESEARCH RELEASE OF INFORMATION**

Acct# \_\_\_\_\_

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: \_\_\_\_\_

**BOULDER VALLEY ASTHMA AND ALLERGY**  
**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

Acct# \_\_\_\_\_

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](http://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)

# 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

Account Number: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

Informant:  Patient  Parent  Other: \_\_\_\_\_

Have you had any previous allergy evaluations?  Yes  No

Current Medications:  None  See Attached

Prescription (include dose and frequency)	Over the Counter/Vitamins/Supplements

Chronic or Past Medical Problems:  None

<input type="checkbox"/> Asthma	<input type="checkbox"/> GERD	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other Autoimmune Disease
<input type="checkbox"/> Angioedema/Anaphylaxis	<input type="checkbox"/> Hay Fever, Nasal Allergies	<input type="checkbox"/> Other Heart Disease
<input type="checkbox"/> Barrett's Esophagitis	<input type="checkbox"/> Hepatitis- Type:	<input type="checkbox"/> Other Liver Disease
<input type="checkbox"/> Blood Clotting Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other Lung Disease
<input type="checkbox"/> Cancer- Type:	<input type="checkbox"/> High Cholesterol/Triglycerides	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hives	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> COPD	<input type="checkbox"/> Immunodeficiency	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Insect Sting Allergy	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Diabetes- Type:	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Eczema	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Stroke
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Eosinophilic Esophagitis	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Osteoarthritis	

List Any Other Serious or Chronic Medical Problems:

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Drug Allergies/Adverse Reactions:  No Known Drug Allergies  See Attached

Medication:	Reaction:

Past Surgical History/Hospitalizations (except for normal births):  None

		Other Surgeries/Hospitalizations:
<input type="checkbox"/> Adenoidectomy	Year: _____	Year: _____
<input type="checkbox"/> Nasal/Sinus Surgery	Year: _____	Year: _____
<input type="checkbox"/> PE Tubes	Year: _____	Year: _____
<input type="checkbox"/> Tonsillectomy	Year: _____	Year: _____

Family History:  Family History Unknown

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

Social History:

<b>Pets:</b>	<input type="checkbox"/> Cats # _____ <input type="checkbox"/> Dogs # _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> None
<b>Second-Hand Smoke Exposure:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Occasional
<b>Tobacco/Substance Use:</b> (complete if age 13 or over)	
<b>Cigarettes:</b>	<input type="checkbox"/> Never <input type="checkbox"/> Former    Age started _____ Age stopped _____ Average # cigs per day _____ <input type="checkbox"/> Current    Age started _____ Average # cigs per day _____
<b>E-cigarettes:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No    How often? _____
<b>Vape:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No    How often? _____ What do you vape? _____
<b>Marijuana:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Occasional
<b>Other Tobacco:</b>	Describe: _____
<b>Alcohol:</b>	<input type="checkbox"/> None <input type="checkbox"/> Former <input type="checkbox"/> Current    Average # of drinks per day _____ per week _____ <input type="checkbox"/> Only Occasional
<b>Other Substance Use:</b>	Describe: _____

## Environmental History:

<b>Heating System:</b>	<input type="checkbox"/> Forced Air <input type="checkbox"/> Hot Water Baseboard <input type="checkbox"/> Radiant Heat <input type="checkbox"/> Wood/Pellet Stove
<b>Air Conditioning:</b>	<input type="checkbox"/> None <input type="checkbox"/> Central <input type="checkbox"/> Window/Wall AC <input type="checkbox"/> Evaporative Cooler
<b>Home:</b>	<input type="checkbox"/> House <input type="checkbox"/> Townhouse <input type="checkbox"/> Condo <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home <input type="checkbox"/> Dormitory
<b>Years in Current Home:</b>	
<b>Age of Home:</b>	
<b>Years Lived in Colorado:</b>	<input type="checkbox"/> Native <input type="checkbox"/> ____ Months <input type="checkbox"/> 1-5 Years <input type="checkbox"/> Over 5 Years <input type="checkbox"/> Over 10 Years <input type="checkbox"/> Over 20 Years <input type="checkbox"/> Does Not Live in CO
<b>Down/Feather Bedding:</b>	<input type="checkbox"/> None <input type="checkbox"/> Pillows <input type="checkbox"/> Comforter <input type="checkbox"/> Mattress Topper
<b>Mattress:</b>	<input type="checkbox"/> Spring <input type="checkbox"/> Foam/Latex <input type="checkbox"/> Air/Water
<b>Age of Mattress:</b>	
<b>Main Living Flooring:</b>	<input type="checkbox"/> Carpet <input type="checkbox"/> Wood/Tile <input type="checkbox"/> Combination of Carpet and Wood/Tile
<b>Bedroom Flooring:</b>	<input type="checkbox"/> Carpet <input type="checkbox"/> Wood/Tile
<b>Basement Flooring:</b>	<input type="checkbox"/> Cement <input type="checkbox"/> Subfloor <input type="checkbox"/> Unfinished <input type="checkbox"/> Carpet <input type="checkbox"/> Wood/Tile <input type="checkbox"/> Crawl Space
<b>Wool Carpeting/Area Rugs:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Other Occupational/Home Exposures:</b>	Describe:

## Current or Recurrent Symptoms (please check all boxes that apply):

<b>General/Constitutional:</b>	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Sweats <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Change in Appetite
<b>Ophthalmologic:</b>	<input type="checkbox"/> Itching <input type="checkbox"/> Redness <input type="checkbox"/> Watering Eyes <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Discharge
<b>ENT:</b>	<input type="checkbox"/> Ear Pain <input type="checkbox"/> Ear Plugging <input type="checkbox"/> Ringing in the Ears <input type="checkbox"/> Recurrent Ear Infections <input type="checkbox"/> PE Tubes <input type="checkbox"/> Runny Nose <input type="checkbox"/> Post Nasal Drainage <input type="checkbox"/> Stiffness <input type="checkbox"/> Sneezing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Loss of Smell/Taste <input type="checkbox"/> Snoring <input type="checkbox"/> Sinus Pressure/Headaches <input type="checkbox"/> Sore Throat <input type="checkbox"/> Itchy Throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Frequent Throat Clearing
<b>Cardiovascular:</b>	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Fainting <input type="checkbox"/> Swelling in Hands/Feet <input type="checkbox"/> Heart Murmur
<b>Respiratory:</b>	<input type="checkbox"/> Productive Cough <input type="checkbox"/> Dry Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest Tightness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Coughing and/or Wheezing with Exercise
<b>Gastrointestinal:</b>	<input type="checkbox"/> Bloating <input type="checkbox"/> Food Allergy <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn <input type="checkbox"/> Difficulty Swallowing
<b>Genitourinary:</b>	<input type="checkbox"/> Frequent Bladder Infections
<b>For Women:</b>	<input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Menopausal
<b>For Men:</b>	<input type="checkbox"/> Prostate Problems
<b>Skin:</b>	<input type="checkbox"/> Itching <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rash
<b>Neurologic:</b>	<input type="checkbox"/> Headache <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Disturbance
<b>Musculoskeletal:</b>	<input type="checkbox"/> Swollen Joints <input type="checkbox"/> Painful Joints <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Back Pain
<b>Endocrine:</b>	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Hair Loss <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Unexplained Weight Change
<b>Psychiatric:</b>	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood Disorder
<b>Hematology:</b>	<input type="checkbox"/> Lymph Node Swelling <input type="checkbox"/> Anemia
<b>Allergy/Immunology:</b>	<input type="checkbox"/> Allergy Swelling/Angioedema/Anaphylaxis <input type="checkbox"/> Frequent Bronchitis/Pneumonia <input type="checkbox"/> Frequent Sinusitis