Alabama Asthma, Allergy & Immunology Center, P.C.

4030 Pepperwood Circle SW, Huntsville, AL 35801 (256) 539-6536

www.huntsvilleallergy.com

Welcome to Alabama Asthma, Allergy & Immunology Center. We appreciate your choice of our clinic to care for your asthma and allergy related conditions. You will receive high quality care from our Physician, Dr. Shashi A.M. Kumar, our Nurse Practitioner, Kim Reisenwitz, and all of our staff.

Dr. Kumar is certified by the American Board of Allergy and Immunology. Dr. Kumar's post graduate training includes specialization in pediatrics at Lloyd Noland Hospital in Fairfield and allergy-immunology at Fitzsimons Army Medical Center in Aurora, Colorado and National Jewish Medical and Research Center in Denver, Colorado. He was a Major in the Medical Corps of the U.S. Army and served as Chief of Pediatrics at Fox Army Hospital on Redstone Arsenal and as Chief of the Allergy Clinical Immunology Service while stationed with the 67th Combat Support Hospital in Wuerzburg, Germany. Dr. Kumar sees children and adults with allergy and immunology problems. He and his wife have twin daughters.

Kim Reisenwitz Our Nurse Practitioner has been with this practice for the past 18 years. She received her Master's Degree in Nursing from the University of Alabama in Huntsville. She has over 35 years of nursing experience and has been nationally certified as a Family Nurse Practitioner since 1991. Kim works in collaboration with Dr. Kumar and is actively involved with the diagnosis, evaluation and treatment of adults and children with asthma and allergic disease. She is married with four adult children and two grandchildren.

As a New Patient…
During your initial visit, a detailed history and physical examination, pulmonary function test (if you have asthma) and skin testing will be performed. For most allergy-related illnesses, every effort will be made to accomplish these tests in one visit. Patients with Blue Cross Blue Shield may require two separate visits for testing per insurance guidelines. A new patient visit may take as long as two hours. All patients will be seen as soon as possible. Please plan to arrive 15 minutes prior to your scheduled appointment time. This extra time will enable you to complete necessary paperwork. Please remember to bring your insurance information and cards with you.

YOU MUST STOP TAKING ALL ANTIHISTAMINE MEDICATIONS (e.g. Benadryl, Chlor-Trimeton, Atarax, Tavist, Claritin, Zyrtec, Allegra, Astelin NS, Astepro NS, etc.) FOR 5 DAYS PRIOR TO YOUR APPOINTMENT. This will enable us to do skin testing on the day of your visit. It is acceptable to continue nose sprays (other than Astelin), decongestants, inhalers, antibiotics and/or oral steroids if you are already taking them. If you have any questions about your medication, please call our office and we will be happy to assist you.

If the patient is under age 18, a parent/legal guardian must accompany the patient and should be familiar with the medical history. If possible, please do not bring other children to the appointment as our examination rooms have limited space for patient and testing supplies.

Again, we thank you for allowing us to assist you in leading a more normal life with your asthma and/or allergy related illness. Please call us if you have any questions about your visit to our office. See you soon!

ALABAMA ASTHMA, ALLERGY AND IMMUNOLOGY CENTER, P.C.

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Huntsville, Alabama 35801
(256) 539-6536

PLEASE DO NOT TAKE ANTIHISTAMINES 5 DAYS PRIOR TO YOUR APPOINTMENT

PERSONAL INFORMATION

Patient's Name_____
First Middle Last Suffix

Mailing Address_____
Street City State Zip

Residential Address_____
(*If mailing address is a PO Box)* Street City State Zip

Home Phone_____ Work Phone_____ Date of Birth_____

Sex: Male____ Female____ Social Security #_____ Marital Status (circle one) S M D W

Patient's Employer_____ Occupation_____

How did you hear about our practice?_____ E-Mail Address_____

Referring Physician's Name_____Telephone #_____ Fax #_____

Pharmacy Name_____ Pharmacy Phone #_____

RESPONSIBLE PARTY INFORMATION

Spouse/Parent/Guardian's Name_____
(Please circle one)

Mailing Address_____
Street City State Zip

E-Mail Address_____

Home Phone_____ Work Phone_____ Date of Birth_____

Social Security #_____ Drivers License #_____

Employer_____ Occupation_____

EMERGENCY INFORMATION

Contact Name_____ Relationship_____Home #_____

Address_____Work #_____

MEDICAL INSURANCE INFORMATION

PRIMARY COVERAGE

Company Name_____

Contract (ID) #_____ Group #_____

Name of Policyholder_____ Relationship to Patient_____

Address of Policyholder_____

Date of Birth_____ Social Security #_____ Drivers License #_____

Employer_____ Work Phone_____

SECONDARY COVERAGE

Company Name_____

Contract (ID) #_____ Group #_____

Name of Policyholder_____ Relationship to Patient_____

Address of Policyholder_____

Date of Birth_____ Social Security #_____ Drivers License #_____

Employer_____ Work Phone_____

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of services to be rendered (e.g. skin testing, RUSH, etc.) by the Alabama Asthma, Allergy and Immunology Center, PC to the patient named above, he/she hereby obligates himself/herself, assumes financial responsibility, and agrees to pay upon demand to provider all charges for such services and incidentals incurred by said patient. Should the account be referred to an attorney/collection agency for collection, the undersigned shall pay all responsible attorney fees and collection expenses. The undersigned understands that all bills are payable upon presentation and that he/she, not the insurance company, is responsible for the payment of all services.

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications

I hereby authorize Alabama Asthma, Allergy and Immunology Center, P.C. to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered on above patient.

Signature of Responsible Party_____ Date_____

ALLERGY HISTORY

Shashi A.M. Kumar, M.D.

1. **Name:** _____ **Sex:** ____ **Age:** _____ **Date of visit**: _____
Referred by / Primary Physician: _____ **Weight:**_____ **Height:**_____

CHIEF COMPLAINT(S): ***Circle the type of problem(s) for which you seek an evaluation***

Hay fever, Asthma, Eczema, Chronic cough, Chronic hives, Food allergy, Drug allergy, Reaction to insect sting, Other

HAY FEVER (nose / sinus / eye) symptoms

2. ***How long have you had hay fever symptoms ?_____ yrs / mths***

(CHECK THAT APPLY)	none	mild	Mod	severe
a) Runny nose				
b) Sneezing				
c) Nasal congestion				
d) Post nasal drip				
e) Red, itchy & watery eyes				
f) Itchiness of nose				
of throat				
of palate				
of ears				
g) Nose bleed				
h) Sinus headaches				
i) Impaired taste / smell				
j) Recurrent sinus infection				

ASTHMA (chest) symptoms

3. ***How long have you had asthma symptoms ?_____ yrs / mths***

(CHECK THAT APPLY)	none	mild	Mod	severe
a) Cough +/- Phlegm				
b) Wheezing				
c) Shortness of breath				
d) Chest tightness				
e) Symptoms with exercise				
f) Lump in the throat				
g) Choking, Loss of speech				

SKIN (Eczema / Hives)

4. ***How long have you had skin symptoms?*** _____

(CHECK THAT APPLY)	none	mild	mod	severe
a) Hives (Urticaria)				
b) Swellings (Angioedema)				
c) Eczema / Dry skin				

Answer question #5 if you have asthma symptoms. If not skip to question #6

5. How often do you have asthma symptoms? Always Daily >2 x per week sporadic Other _____
Do asthma symptoms wake you up at night? YES / NO if yes, how many times a month / week _____
Number of Emergency Room / Urgent care visits for asthma in the past 12 months _____
Ever hospitalized for asthma? YES / NO Number of hospitalizations? _____ Last hospitalization _____
Number of times on oral steroid courses (e.g.; Prednisone, Medrol dose pack, Steroid shots) in the past 12 months _____
How many days of work or school have you missed due to asthma in the past 12 months _____
Do you monitor peak flows at home? YES / NO. If so, what is your ideal peak flow? Morning _____ Evening _____
Do you have stomach reflux symptoms (sour belching, heartburn, pain or difficulty swallowing) YES / NO

6. Do your symptoms vary with the seasons? YES / NO

If YES, place an "X" in the boxes when symptoms are worse

Symptoms	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Hay fever												
Asthma												
Eczema												
Hives												

7. Are you up to date on routine childhood vaccinations (immunizations)? YES / NO
Influenza vaccine received: YES / NO when? _____ (Flu)
Pneumococcal vaccine received: YES / NO when? _____ (Pneumonia) (Pneumovax or Prevnar)

List over-the-counter and Prescription drugs used: (include dose and frequency of use)

CURRENT

_____
_____
_____
_____
_____

PAST

_____
_____
_____
_____
_____

Please continue on the next page

8. ***Check those triggers that cause or worsen your symptoms***

Hay fever	Asthma	Eczema / Hives	Triggers (circle or check all applicable)
			House Dust (Vacuuming, Dusting, Making bed, Shaking bed, Cleaning, sweeping)
			Animals (cats, dogs, hamster, birds, guinea pig, other _____)
			Respiratory infections (Colds, sinus infections, Flu, Bronchitis)
			Exercise
			Night time
			Strong odors (detergents, paint fumes, newsprint, gasoline, diesel fumes)
			Cosmetics, Perfumes, Air refreshners, Cleaners, Hair spray, etc.
			Emotional upset (Stress, Worry), Laughing
			Smoke (Tobacco, Auto exhaust, other _____)
			Cold air (air conditioning or outside air)
			Weather changes: Rain _____, Cold Fronts _____, Thunderstorm _____, Wind_____
			Smog (Air pollution)
			Drugs (aspirin / Ibuprofen, blood pressure medicine, glaucoma drops)
			Grass mowing, Raking leaves
			Foods / Food additives eg: Sulfites (in dried fruits, wine, beer etc) / other _____
			Menstrual cycle, Pregnancy

9. ***Other allergies*****: Food allergy?** YES / NO **Insect Sting allergy** (Bee, YJ, Wasp, Hornets, Fire ants)**?** YES / NO
Drug allergy? YES / NO **Latex rubber allergy?** YES / NO

Have you undergone allergy tests? YES / NO By whom? _____
Please list the results of your allergy testing ?_____
Have you received allergy shots in the past? YES / NO when and how long?_____
Did the allergy shots help your symptoms? YES / NO _____

10. ***Home/Environmental survey*** ***(Fill in the blanks and circle those that apply)***
Years at present address: ____ ***Age of dwelling****: ____* ***Dwelling Type:*** House Apartment Trailer Other _____
Trees around the house: Cedar Oak Maple Elm Pecan Pine Other _____ ***Lawn grass****:* Bermuda Fescue Other _____
Visible allergens inside the house: Mold-Mildew Roaches Rodents ***Indoor plants:*** Yes / No
Type of heating: Forced air Gas Radiators Electric Wood burning Space heaters Other_____
Type of cooling: Central Window unit fans none ***Humidifier use:*** *(Central / Portable) YES / NO*
Any indoor animals? (Dog, cat, hamster, bird, guinea pig, other _____) ***Outdoor animals?*** (cat, dog, horse, cattle, other_____)
Type of bed: Mattress / Box spring Waterbed Foam other ***Comforter***: Feather / Non-feather
Type of pillow: Foam Feather Down Kapok Synthetic *Water leakage or damage in your home*: Yes / No
Carpets? YES / NO ***Basement present***? YES / NO *If yes, is it Damp*? Yes / No
Latex exposure in the home? Check all that apply (__ Playtex gloves __ Balloons __ Condoms or diaphragm)

11. ***Review of medical problems*** ***(Circle if present)*** Poison ivy/oak dermatitis Chr snoring Sleep apnea Nasal polyps
Heart burn/Reflux Stomach ulcers Hepatitis HIV/AIDS Diabetes Thyroid disorder Weight loss Glaucoma Hypertension
Elevated cholesterol Angina Heart failure Kidney stone Chr bronchitis/Emphysema Chr abdominal pain Chr diarrhea Colitis
Arthritis Migraine Anxiety/Depression Anemia Osteoporosis

12. ***Past history of diseases***: ***(Circle if present) List surgeries _____***
Asthma Eczema/Atopic dermatitis Acute/Chronic hives Thyroid disorder
Recurrent Pneumonia Recurrent Sinus infections Recurrent ear infections Ear tubes
Sinus surgery Tonsils surgery Adenoids surgery Nasal Polyps Migraines

13. ***Family History*** Do any of your family members (parents, siblings, children) have the following conditions?
Hay fever Asthma Eczema Drug allergy Food allergy Chronic hives HAE Colitis
Sinus problems Nasal Polyps Cystic Fibrosis Emphysema Arthritis Migraine Glaucoma
Anxiety / depression Immune deficiency Hypertension Diabetes Thyroid disorder

14. ***Social History***
Marital Status: ____ **Currently Pregnant:** YES / NO ***Current Occupation***: _____ ***Exposure to chemicals at work****:* YES / NO
Hobbies: _____ ***Smoking?*** YES / NO ***Year started smoking? _____*** ***Number of Cigg / day _____***
Quit smoking? Year _____ ***Does anyone smoke inside your home?*** YES / NO

History reviewed with the patient in detail YES / NO Shashi A.M. Kumar, MD

ALABAMA ASTHMA & ALLERGY CLINIC

OUR FINANCIAL POLICY

Thank you for choosing **Alabama Asthma, Allergy & Immunology Center, P.C.** as your health care provider. We are committed to your treatment being successful. Our Insurance/Collections Specialist will work very hard to make sure your paperwork is filed accurately and promptly.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that our Practice requires you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECK, VISA & MASTERCARD

Regarding Insurance

We accept most major insurance companies and all co-pays, co-insurance and deductibles are due at the time of service. If your insurance company has not paid or denied your claim within 30 days for electronic filing and 45 days for hardcopy filing, our office may require your assistance in reporting this to your insurance benefits coordinator and the State of Alabama Insurance Commissioner. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. In these cases of elective or non-covered services, you will be required to sign a non-covered form before services are provided agreeing to be personally and fully responsible for payment of these medical services. In the event that your insurance coverage changes to a plan where we are not participating providers, you are responsible for all out-of-network charges.

Referrals & Authorizations

It is your responsibility to provide any required referral forms for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will need to be rescheduled or you will be required to sign a referral waiver form that makes you financially responsible.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to Visa/MasterCard or payment by cash or check at time of service has been verified.

Divorce Decrees

This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Statements & Collection Letters

If you have a balance on your account after your date of service(s), you will receive statements and collection letters each month until payment in full is received on your account. If you do not make payment arrangements with our office in advance, we reserve the right to transfer your account to a collection agency once your account reaches 90 days old.

Returned Checks

Our office charges a returned check fee of $28.00 on ALL returned checks.

Medical Forms & Letters

There is a charge for all completed medical forms and letters. Simple letters and forms incur a fee of $25. The fee will be increased for more detailed and lengthy form or letters.

Missed Appointments

Unless canceled, at least 24 hours in advance, our office reserves the right to charge for missed appointments at the rate of a normal office visit to the extent authorized or allowed by law. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please contact Doreen Reid, Insurance/Collections Specialist, if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____ Date _____

Signature of Patient or Responsible Party

X _____ Date _____

Signature of Co-Responsible Party

Dear New Patient:

We would like to thank you for choosing our office for your medical needs. Our promise is to improve the quality of life of our patients who suffer from chronic allergies and asthma through the delivery of exceptional care and service by our exceptional physician, Dr. Kumar, and his caring staff.

As a new patient, it is important that we inform you of some important matters:

1. **Be sure that you do not take any antihistamines 5 days before your visit.** This enables us to perform allergy skin testing during this visit.

2. Your insurance carrier may require you to obtain a pre-authorized and/or referral from your primary care physician for your visit and/or treatment at our office. You will need to contact your insurance carrier or your personnel director to complete any necessary procedures to ensure your visits and/or treatment will be covered by your insurance carrier. If you do not obtain the appropriate pre-authorization and/or referral and your carrier denies your claims, you will be responsible for your account balance.

3. Please complete the enclosed new patient information forms. Also read and sign our financial policy and bring all of these forms along with your insurance card(s) and driver's license to the office at the time of your visit.

4. Patients that do not have insurance coverage must contact our office prior to appointment date to discuss financial arrangements.

5. As stated in our financial policy, patients that have insurance coverage must pay his/her co-payment, coinsurance and/or deductible **at the time of service.**

6. As a courtesy to other patients and our office staff, if you need to cancel an appointment, please contact our office **at least 24 hours in advance.** This policy allows us to make your cancelled appointment time available to another patient. **Effective September 1, 2005 there will be a charge of $25 for all missed appointments that are not cancelled within 24 hours.**

Please feel free to visit our website at www.huntsvilleallergy.com for more information about our practice and feel free to give us a call if you have any questions. We hope that your visit with us exceeds your expectations and if there is anything we can do to make your visit better, please do not hesitate to let us know. We will see you soon.

Sincerely,
The Staff of Alabama Asthma, Allergy and Immunology Center, P.C.

Alabama Asthma, Allergy & Immunology Center, P.C.

When Should I See an Allergist?

An allergist is a physician who specializes in the diagnosis and treatment or allergic rhinitis (hay fever), asthma and other allergic diseases (insect sting allergy, food allergy, drug allergy, hives, eczema, anaphylaxis). The allergist has special training to identify the factors that trigger allergic diseases, and help patients to prevent or treat these conditions. After earning a medical degree, the allergist completes a three-year residency training program in either internal medicine or pediatrics, followed by a two- or three-year program of study in the field of allergy and immunology. After passing a qualifying examination, the doctor becomes an allergist certified by the American Board of Allergy and Immunology.

How an Allergist Can Help

Effective control of allergic disease requires planning, skill and patience The allergist, with his or her specialized training and expertise in evaluation and management, can develop a treatment plan For your individual condition. The goal will be to enable you to lead a life that is normal and symptom-free as possible.

Allergy Testing
The allergist will usually perform skin tests to determine what allergens are involved.

Environmental control
The most effective approach to treating allergic symptoms is to avoid the factors that trigger the condition in the first place. Even when it is not possible to avoid allergens, an allergist can design strategies for reducing exposure and preventing symptoms.

Prescription Medications
Many new and effective medications are available to treat allergic diseases.

Immunotherapy (Allergy Shots)
In this treatment, patients are injected over the course of time with gradually increasing doses of the substances to which they are allergic. In many cases, the body's reaction to the substance becomes less pronounced over time.

You Should See an Allergist if:

- Your nasal allergies are causing secondary symptoms such as chronic sinus infections, nasal congestion or difficulty breathing.
- You experience hay fever or other allergy symptoms several months out of the year.
- Antihistamines and other over-the-counter medications do not control your allergy symptoms or create unacceptable side effects, such as drowsiness.
- Your allergic disease is interfering with your ability to carry on day-to-day activities.
- Your allergy symptoms decrease the quality of life.
- You are experiencing warning signs of asthma such as: 1.You often wheeze or cough, especially at night or after exercise. 2. You have previously been diagnosed with asthma, but despite treatment, you have frequent acute asthma attacks.

Patient name(please print):_____ Date of Birth:_____
Account #:_____

SURGICAL HISTORY – Please check off any procedure or surgeries. □ **NONE**

Surgical Procedure	**Yes**
Adenoidectomy	
Ankle Repair	
Appendectomy	
Bunionectomy	
Carpal Tunnel Release	
Cataract Surgery	
Cesarean Section	
Coronary Bypass	
D & C **(females only)**	
Endometrial Ablation **(females only)**	
Foot Repair	
Gallbladder Removal	
Gastric Bypass	
Hiatal Hernia Repair	
Hip Replacement	
Hysterectomy	
Inguinal Hernia Repair	
Knee Replacement	
Knee Surgery	
Laminectomy	
Lumpectomy of Breast	
Nasal Polypectomy	
Nasal Septoplasty	
Ovarian Removal	
PE Tubes (Ears)	
Prostatectomy	
Rotator Cuff Repair	
Sinus Surgery	
Tonsillectomy	
Umbilical Hernia Repair	
UPPP (Sleep Apnea)	
Vasectomy	
Wisdom Teeth/Tooth Extraction	
Other (list)	
Other (list)	

Please complete both sides

Patient name(please print):_____ Date of Birth:_____
Account #:_____

FAMILY HISTORY – Indicate which relative has had the following diseases.

Disease	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**	**Other**	**No**
Allergic Rhinitis								
Anxiety								
Arthritis								
Asthma								
Autoimmune Disorder								
Chronic Urticaria								
Colitis								
Coronary Artery Disease								
Cystic Fibrosis								
Depression								
Diabetes								
Drug Allergy								
Eczema/Atopic Dermatitis								
Emphysema								
Food Allergy								
Glaucoma								
Hereditary Angioedema								
Hypertension								
Hyperthyroidism								
Hypothyroidism								
Immunodeficiancy								
Migraine								
Nasal Polyps								
Sinus Problems								

Please list all drug allergies. Include the drug name and type of reaction.

Drug Name	**Type of Reaction**

Please complete both sides