



BOARD CERTIFIED IN ALLERGY & IMMUNOLOGY
Treating patients of all ages

GARRICK P. HUBBARD, M.D.

JENNY CASBURN, FNP-C

Dear New Patient:

We would like to welcome you to Allergy & Asthma Care of Indiana and look forward to caring for your allergy needs. We have three office locations; please be certain of the correct location of your appointment.

- ❖ 11590 North Meridian Street, Suite 400, Carmel, Indiana 46032
- ❖ 1815 North Capitol Avenue, Suite 405, Indianapolis, Indiana 46202
- ❖ HRH Professional Building, 1 Memorial Square, Suite 330, Greenfield, Indiana 46140

A parent or legal guardian must accompany all minors under 18 years of age. The initial visit to our office will often take 2 hours or more, and any necessary skin testing will most likely be completed during that time. Because we have set aside a significant amount of time for your appointment, if you need to cancel, please do so at least 24 hours in advance.

It is extremely important that you read the "MEDICATIONS TO HOLD" information at least 10 days prior to your scheduled visit. If you feel you cannot do without your medication(s), please contact our office and discuss this with us.

If you are currently taking any medications, please bring these with you. Otherwise, contact your doctor or pharmacist for a complete list of your medications. Please bring pertinent records, labs, and written reports of any imaging studies (x-rays, CT scans) with you.

It is helpful if you wear short sleeves to the appointment. All persons attending the appointment MUST refrain from using perfume and/or cologne on the day of your appointment with us. Also, please do not smoke and try to avoid being around smoke prior to coming into the office, as both of these irritants pose a significant health hazard to many of our patients.

Upon arrival, our receptionist will copy your picture ID and insurance card. We will also file an insurance claim for you. Per our Patient Financial Policy and contractual agreements with your health plan, **you will be required to pay your office visit co-pay at the time of your visit.** To assist you in making this payment, all of our offices accept MasterCard, Visa, and Discover. Our practice participates in the Medicare Program and with most commercial health insurance plans. However, it is your responsibility to verify with your health plan that the doctor you will be seeing is an enrolled provider, as health plan networks change frequently. If you have any questions about our participation in your plan(s), please contact our office. If your insurance requires a written authorization to see a specialist, please contact your primary care physician to obtain the referral PRIOR to your visit. Remember, your insurance agreement is between you and your insurance company. Any unpaid balance will be your responsibility.

In the New Patient Section of our website, you will find several forms that we ask that you print and complete. Please bring the completed forms with you, as this will help to speed up your check-in. Please arrive 10-15 minutes prior to your scheduled appointment to allow time for us to process the information for your file. We appreciate your interest in our practice and look forward to helping you with any allergy and/or asthma treatment.

MEDICATIONS TO HOLD FOR SKIN TESTS AND ORAL CHALLENGES

Allergy & Asthma Care of Indiana

STOP 7 or 10 DAYS BEFORE APPT.	STOP 3 DAYS BEFORE APPT.	DO NOT TAKE MORNING OF APPT.	LAST DOSE NIGHT BEFORE APPT.
<p><u>*Antihistamines/ Cold Meds (7 days):</u> Allegra (fexofenadine), Alavert, Clarinex (desloratadine), Claritin (loratadine), Xyzal (levocetirizine), Zyrtec (cetirizine), Actifed, AlleRX, Bromfed (brompheniramine), Chlortrimeton, Codimal, D'Allergy, Dimetapp, Duratuss, DuraVent, Polyhistine- D, Promethazine, Rondec, Ru-Tuss, Rynatan, Rynatuss, Semprex-D, StaHist, Tavist (clemastine), Trinalin, Tussicaps, Tussi-12D, Tussionex, Allergy/Sinus meds, cough drops Dicel, Palgic, Atarax (hydroxyzine), Phenergan (promethazine)</p> <p><u>Eye Drops(7days):</u> Optivar, Zaditor, Alaway (ketotifen)</p> <p><u>Nasal Sprays (10 days):</u> Astelin, Astepro, Patanase</p>	<p><u>*Antihistamines</u> Benadryl</p> <p><u>Heartburn meds:</u> Pepcid, Tagamet, Zantac, Axid</p> <p><u>Vertigo/Dizziness Meds:</u> Antivert (meclizine)</p> <p><u>Eye Drops:</u> Elestat, Pataday, Patanol</p> <p><u>Over-the-counter pain/sleeping aids with "PM"</u> ex: Tylenol PM</p>	<p><u>•Inhalers:</u> Albuterol, Combivent, Maxair, Proventil, Terbutaline, Ventolin, Xopenex, ProAir</p> <p><u>•ONLY hold above inhalers IF symptoms allow</u></p> <p><u>If you have an afternoon appt, refrain from using inhalers after 8:00 am.</u></p>	<p>Advair, Foradil, Spiriva, Serevent, Symbicort, Dulera</p> <div style="border: 2px solid black; padding: 5px; margin-top: 10px;"> <p><u>NO RESTRICTIONS:</u></p> <p><u>Inhalers:</u> Alvesco, Aerobid, Atrovent, Azmacort, Asmanex, Beclovent, Flovent, Intal, Pulmicort, QVAR.</p> <p><u>Nasal Sprays:</u> Flonase (fluticasone), Nasacort, Nasonex, Omnaris, Veramyst</p> <p><u>Other:</u> Accolate, Singulair, Theophylline, Zflo, topical steroid creams such as hydrocortisone cream</p> </div>

***If evaluation is for hives, it is OK to continue antihistamines.**

****MUST** obtain permission from PCP BEFORE discontinuing the following medications; these medications need to be held 7 days OR LONGER.

****Antidepressants, sleeping aids:** doxepin, Elavil (amitriptyline), Norpramin (desipramine), Pamelor (nortriptyline), Surmontil (trimipramine), Vivactil (protriptyline)

If you have any questions, or you feel you cannot go without a medication, please contact us at 317-708-2839.

ENVIRONMENTAL AND SOCIAL HISTORY

What is the main problem that brought you here today? _____

Name _____ Date of Birth _____

Please check all that apply

HOME:

Do you live in a ... City Town Rural Area

Do you live in a ... House Apartment Other _____

How long have you lived in your current place of residence? _____ years _____ months. Age of home? _____

What type of heating system do you have?

Central Forced Air Radiator Wood-burning stove Other _____

Air-Conditioning? None Central Window Units

Dehumidifier? None Main Level Basement Other _____

Humidifier? None Central Separate Units

Air Cleaner/Purifier? None Central Separate Units in the Bedroom

Basement? Yes No

If yes, is the basement... Damp Musty Seepage Flooding Dry

BEDROOM: Is your bedroom in the basement? yes / no

Dust Mite / Allergy Covers on mattress? Yes No On Pillows? Yes No

Pillow: Feather/Down Synthetic Fiberfill Other _____

Do you have any of the following in the bedroom?

None Stuffed Animals Toys Collectibles Bookshelves

FLOORING:

Living area: Carpet yes / no

Bedroom: Carpet yes / no

Basement: Carpet yes / no

PETS: None Dog Cat Bird Other _____

Do your pets go in the bedroom? Yes No

Do your pets sleep on/in the bed? Yes No

If your child is the patient, is he/she exposed to pets in daycare or school? Yes No
If yes, type? _____

Are there live plants in the bedroom? Yes No

Are you exposed to second-hand smoke at home? Yes No

NAME _____ DATE _____

FAMILY HISTORY:

Does anyone in your family have nasal allergies or hay fever?

- No Parents Siblings Children Other _____

Does anyone in your family have food allergies?

- No Parents Siblings Children Other _____

Does anyone in your family have asthma?

- No Parents Siblings Children Other _____

Does anyone in your family have eczema?

- No Parents Siblings Children Other _____

Does anyone in your family have hives / welts?

- No Parents Siblings Children Other _____

Does anyone in your family have cystic fibrosis?

- No Parents Siblings Children Other _____

PAST MEDICAL HISTORY:

Surgical procedures / year: _____

Hospitalizations / reason / year: _____

SOCIAL HISTORY:

Smoker Non-Smoker Past Smoker How long? _____ How much? _____ When did you quit? _____

Occupation _____

Do you have any medical problems with the following: (Please check Yes or No)

	Yes	No	Describe
Ears			
Sinuses			
Eyes			
Heart			
Lungs			
Stomach			
Ulcers			
Reflux disease / heartburn			
Bladder or Kidney			
Skin			
Neurological			
Diabetes			
Thyroid			
Blood Disorders			
Other			

ALLERGY & ASTHMA CARE OF INDIANA/PATIENT REGISTRATION

Date _____

Name _____ Male or Female _____ Single Married Other _____
Last First Middle

Address _____ City _____ State _____

Zip _____ Home Phone# () _____ Cell Phone # () _____

Social Security# _____ DOB _____ EmailAddress: _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____ Work Phone# () _____

If patient is a minor, provide Mother's Name _____ Father's Name _____

PRIMARY INSURED PARTY INFORMATION

Name _____ Male Female _____ DOB _____
Last First Middle

SS# _____ Relationship to Patient _____ Home Phone# () _____

Address _____ City _____ State _____ Zip _____

Employer _____ Address _____

City _____ State _____ Zip _____ Work Phone# () _____

SECONDARY INSURED PARTY INFORMATION

Name _____ Male Female _____ DOB _____
Last First Middle

SS# _____ Relationship to Patient _____ Home phone # () _____

Address _____ City _____ State _____ Zip _____

Employer _____ Address _____

City _____ State _____ Zip _____ Work Phone # () _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone# _____ Cell# _____

PRIMARY CARE PHYSICIAN

Name _____ Address _____ Phone# _____

REFERRED BY

Name _____ Address _____ Phone # _____

ALLERGY & ASTHMA CARE OF INDIANA PATIENT FINANCIAL POLICY

Thank you for choosing us as your specialty health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. Our staff is trained to inform you of the financial policies of this practice. This document must be read and signed by each patient and will remain in effect for all services rendered during your time as a patient in our practice.

INFORMATION:

A current registration will be on file in the patient chart during the time that the patient is considered active. Patient registration will be updated yearly and will include numbers for the patient including home phone, cell phone and work phone. A signature by the responsible party is required. On an annual basis, or as needed, we will ask for a photocopy of your insurance card for your file.

Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance carrier unless you give us your insurance information. Failure to provide us with accurate information can result in denied claims, which are then the responsibility of the patient.

INSURANCE CLAIMS:

I am authorizing Allergy & Asthma Care of Indiana (AACI) to furnish information to insurance carriers concerning the illness or medical treatment of myself or dependents and I hereby assign to the provider all insurance payments for medical services rendered to myself or my dependent, except for those services for which I have already paid prior to the filing of the insurance claim on the behalf. In addition, I hereby designate AACI as my representative to file grievances and to represent me in accordance with the Indiana Code, title 27, Chapters 8 and 13. I also knowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in the responsibility.

Primary Insurance: Allergy & Asthma Care of Indiana (AACI) will file your medical claim upon proof of insurance; (i.e., insurance card indicating coverage, identification number, group number and remittance address for claims). As part of your insurance contract, full payment for ***“your part”*** of the charges is expected from you at the time of service. ***“Your part” of your charges is defined as any co-pays, deductibles or non-covered service charges that are incurred on the date of service.*** If you do not come prepared to pay your co-pay at the time of service, we will provide you with a self addressed stamped envelope for you to remit payment to us immediately. Should any co-pay go unpaid for 2 weeks, an additional \$10.00 administrative charge will be added to your balance. If the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of your insurance card, AACI will then submit a claim to your insurance carrier.

Please be aware that some, and in rare cases all, of the services provided *may* be non-covered services and not considered payable under your insurance plan. You need to contact your insurance carrier prior to your appointment for your coverage benefits. If you choose to keep your appointment even though your carrier may deny your claim, you will be asked to sign a waiver stating you will be responsible for payment of all services. If your insurance carrier requires you to obtain a referral for the office visit, you are responsible for obtaining that referral. If no referral is obtained and you wish to be seen, a waiver must be signed stating you are responsible for the payment if your primary care physician will not authorize the referral.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service.

PATIENT FINANCIAL RESPONSIBILITY:

If no insurance is to be filed by AACI, or if AACI is not a participating provider in your insurance network, and you do not have out-of-network benefits, **full payment is due at the time of service unless other arrangements have been made. If you receive injections and need new vials, your previous vials will need to be paid in full and your balance must be under \$500.00 for new vials to be mixed. Please be prepared to pay any co-insurance/copays/deductible at the time of each injection.**

A finance charge of 1% (monthly) may be applied to any balance unpaid after 45 days of receipt of insurance payment.

MINORS/DEPENDENTS:

Children under the age of 18 will require the signature of a responsible adult party on the registration form. An adult is required to accompany children under the age of 13 to all office visits.

METHOD OF PAYMENT:

Acceptable methods of payment are cash, check, Visa and MasterCard. Visa and MasterCard will be accepted by phone or fax. Any returned check will result in an additional fee of \$25.

ACCOUNTS PAST DUE:

Payment from each statement is due upon receipt. Non-compliance may result in preparation of account for small claims court, collection agency and/or credit bureau reporting and possible discharge from the practice.

In the event an account is turned over for collection the person financially responsible for the account will be responsible for the cost of collections which includes, but is not limited to, collection agency fees, reasonable attorney's fees, court costs, witness costs and prejudgment interest of 8% per annum. Each party further agrees that the Marion County circuit, Superior, or Small Claims Court shall be the proper court of jurisdiction and venue. Further, each party waives trial by jury.

A patient may remit in full to the collection agency all outstanding charges owed on account and include amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

CONFIRMATION OF APPOINTMENTS

AACI will call you to confirm your office appointment. We will leave a message on your voice mail or with a family member if you are unavailable. At that time, if there is a balance due on your account we will provide you with that balance and ask that you come prepared to pay the balance in full or make a payment on the account.

MISSED APPOINTMENTS:

AACI requires 24-hour notice of appointment cancellation. Appointments missed and not cancelled prior to 24 hours will be charged a "no show" fee of \$25.00. Four (4) late cancellations, with less than 24 hours notice, may result in discharge from the practice.

ACCOUNT CONSULTATION:

Physicians do not discuss financial issues. Our account representative will be happy to discuss your account, and if needed, set up a monthly payment plan. If further assistance is needed, our Practice Manager, can be consulted as well.

MEDICAL RECORDS:

If you require copy of your records or would like us to transfer your records to another physician, there will be a \$10.00 administrative fee for copying the first 10 pages and .50 for each page thereafter. There may be an additional charge for postage or faxing records. This fee must be paid prior to the transfer of the records. You will also be asked to sign an authorization form stating the transfer of records. Should we refer you to another physician; copies of your records will be provided to them at no cost.

Your signature below indicates that you accept and understand this policy. Further, your signature authorizes AACI, to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to AACI when an assigned claim is filed.

I have received a copy of the AACI financial policy.

Print Patient's Name
Revised 1/08

Signature (patient or responsible party)

Date

Allergy and Asthma Care of Indiana

Garrick Hubbard, MD ▪ Jenny Casburn, NP-C ▪ Maggie Blettner, NP-C
Main Phone 317 708 2839 ▪ Fax 317 708 2877

11590 N Meridian St #400 Carmel, IN 46032 ▪ 1815 N Capitol Ave #405 Indianapolis, IN 46202 ▪ One Memorial Sq. #330 Greenfield, IN 46140

Limited Patient Authorization for Disclosure of Protected Health Information to an Individual

Please print all information. Form must be signed and dated yearly in order to be valid.

Patient Name: _____ DOB: _____

Please indicate below if it is okay to leave protected health information via voicemail(s) on your home and cell

Yes No or Please indicate phone number(s) _____

I authorize Allergy and Asthma Care of Indiana to disclose or provide protected health information about me to the individuals listed below:

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Information to be disclosed may include medical or financial information such as lab or x-ray results, current health record, previous/other provider health records, and/or payment information.

Or (please specify) only the following information: _____

This authorization will expire at the end of the calendar year of your last signature below. You must renew or submit a new authorization after the expiration date to continue the authorization.

You have the right to terminate this authorization at any time. You must notify us in writing if you decide to terminate the expiration prior to the end of the signed calendar year.

You are in no way obligated to sign this form in order to receive medical treatment.

We have no control over the person(s) you have listed to receive your protected health information and cannot be responsible for how they choose to use or share the information once it is disclosed.

Patient Signature

Date

Patient Signature

Date

Patient Signature

Date

Patient Signature

Date

Patient Signature

Date

You have a right to receive a copy of signed authorizations upon request.