Holy Rosary Healthcare
2600 Wilson Street
Miles City, Montana 59301

Central Montana Medical Center
310 Wendell Ave.
Lewistown, Montana 59457

Montana Allergy and Asthma Specialists -Yellowstone Medical Center
2900 12th Ave. N, Suite 302 E, Billings, MT 59101
Phone: 406-237-5500 Toll Free: 1-800-308-3719 Fax: 406-237-5510
www.mtallergy.com

Patient Name _____

Appointment Day/Date: _____ Appointment Time: _____

IMPORTANT INFORMATION FOR PATIENTS

Please read before your next scheduled visit with Montana Allergy and Asthma Specialists.

Thank you for choosing Montana Allergy and Asthma Specialists! We look forward to seeing you at your scheduled appointment. Enclosed you will find an allergy history questionnaire. **Please complete this and bring it to your appointment.** If you have any questions, please do not hesitate to contact our office. **Please arrive 10 minutes prior to your appointment for registration.**

Allergy skin testing, which is often preformed on the initial visit, can be unreliable when prescription and "over-the-counter" antihistamines are being used. For this reason, we ask you to **avoid all antihistamines for five days prior to your initial visit**

PLEASE CHECK YOUR MEDICATIONS FOR ANY OF THESE INGREDIENTS AND STOP THESE MEDICATIONS:

- Actifed
- Ak-Con-A eye drops
- Alavert
- Allercon
- Allerfrim
- Allegra (fexofinadine)
- Atarax (hydroxyzine Hydrochloride)
- Axid (nizatidine)
- Azatidine
- Azelastine
- Balamine-DM (carbinoxamine)
- Benadryl (diphenhydramine) - topical or oral
- Carbinoxamine (Balamine-DM)
- Cetirizine (Zyrtec)
- Chlorpheniramine (Coricidin)
- Chlor-Trimeton
- Cimetidine (Tagamet)
- Clarinex
- Claritin
- Coricidin (chlorpheniramine)
- Dexbrompheniramine (Drixoral)
- Dimenhydrinate (Dramamine)
- Dimetapp
- Doxepin
- Dramamine (dimenhydrinate)
- Drixoral (dexbrompheniramine)
- Famotidine (Pepcid)
- Fexofinadine (Allegra)
- Histafed
- Hydroxyzine - Vistaril
- Hydroxyzine Hydrochloride - Atarax
- Loratadine
- Naphcon-A eye drops
- Nyquil
- Op-Con-A eye drops
- Patanol eye drops (olopatadine)
- Pataday eye drops (olopatadine)
- Patanase nasal spray (olopatadine)
- Pazeo (olopatadine)
- Pepcid (famotidine)
- Percogesic (phenyltoloxamine)
- Periactin
- Phenergan
- Phenyltoloxamine (Percogesic)
- Prednisone for greater than thirty days
- Promethazine
- Pyrilamine (diuretic)
- Robitussin (avoid ALL except PLAIN)
- Sinequan (doxepin)
- Steroid injections in the past three months
- Tagamet (cimetidine)
- Tavist
- Tylenol PM, Excedrin Pm, Etc.
- Tylenol Cold and Sinus
- Vistaril (hydroxyzine)
- Xyzal
- Zantac
- Zyrtec (cetirizine)
- Zaditor

How did you hear about us? Please circle all that apply.

Web:

Radio: K-Bear 97.1 FM News Radio 970 AM The Hawk 103.7 KMHK FM Channel95AM

Cat Country 102.9 KCTR Miles City KYUS 92.3 FM HOT 101.9 KRSQ-Laurel

Magazine: Magic City Simply Family Yellowstone Valley Women

Newspaper: Billings Gazette Montana Best Times Miles City Lewistown New Argus

TV: _____ Family / Friends: _____

Phone Book:_____ Charity / Local Organization: _____

Other: _____ Physician Referral: _____

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Other: _____ Physician Referral: _____

Montana Allergy and Asthma Specialists:
Frequently Asked Questions regarding Insurance Coverage

1. **Will my insurance cover my office visit and procedures at Montana Allergy and Asthma Specialists?**

   a. Make sure that your insurance will cover the costs incurred at our office. There are certain insurance plans that do not have Montana Allergy and Asthma Specialist as a preferred provider. These insurance plans are usually Billings Clinic only networks. Check before your appointment so that there are no surprises.

   b. If you have **Medicaid**, make sure that your passport provider is aware of your appointment and ask them to grant passport referral access to Montana Allergy and Asthma Specialists. Without passport, Medicaid will not cover the costs.

   c. If you have **Tricare Prime** or **Tricare Prime Remote**, make sure that you have referrals from both primary care physician and United Tricare. Without referrals, United Tricare will not cover the costs.

2. **How will my insurance benefits apply to services at Montana Allergy and Asthma Specialists?**

   a. While 99.9% of insurance plans will cover allergy benefits, there are many different ways to apply benefits. Some will cover all costs. Some will be covered under the copay. Some will be subject to the deductible and coinsurance. Some will have the deductible waived. Some will have an entirely different plan. Check with your insurance prior to the visit if you have questions or concerns.

      i. We have provided the most common codes that your insurance company may request. All will be conducted by a specialist in an office setting.
         1. Office Visit: 99241-99245, 99201-95205, 99211-99215
         2. Allergy Testing: 95004
         3. Spirometry (measuring lung function): 94010
         4. Bronchospasm eval: 94060
         5. Allergy Testing (Patch Testing): 95044
         6. Allergy Testing (Venoms): 95017
         7. Allergy Testing (Drugs): 95018
         8. Ingestion Challenge: 95076
         9. Sinus CT Scan: 70486
         10. Allergy Serum: 95165
         11. Venom Serum: 95145, 95146, 95147, 95148, 95149
         12. Allergy Injection: 95115, 95117

      ii. We are more than willing to help you prior to the exam. Call us with any questions

3. **How will my insurance cover my labs ordered by Montana Allergy and Asthma Specialists?**

   a. Sometimes, we may need to order labs for further analysis. All analysis and blood draws are conducted at PAML which is a completely independent business and utilizes their own billing. If you are concerned about the cost of any labwork, please contact PAML and your insurance company for pricing: PAML 1-800-349-8586.

Montana
Allergy and Asthma
SPECIALISTS

Patient Demographic Form

Last Name: _____ First Name: _____ Preferred: _____

DOB: _____ SSN: _____

Sex: Male / Female Race / Ethnicity: _____

Address: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

How would you prefer reminders about appointments: Circle all applicable: Text Phone Email

Guarantor Information

Name of Person Financially Responsible of Account: _____

Address if not the same as the patient: _____

DOB: _____ SSN: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Other Family Relations Authorized to discuss account (mom, dad, grandparents)

	Name	Relation
1		
2		
3		
4		
5		

Who is your primary care doctor? _____

Montana
Allergy and Asthma
SPECIALISTS

Limited Patient Authorization for Disclosure of Protected Health Information
Please print all information. Form must be signed and dated each year.

Patient Name: _____ **Date of Birth:** _____

I authorize Montana Allergy PLLC to disclose or provide protected health information, about me to the individual(s) listed below.

Name:_____ Name: _____ Name: _____

Address: _____ Address: _____ Address: _____

Phone: _____ Phone:_____ Phone:_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:
- ☐ office notes
- ☐ lab results, pathology reports
- ☐ CT Scans
- ☐ financial history report (previous 3 years only).
- ☐ Only send the following: _____

Purpose of disclosure

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our office. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or representative signature date

Notice of Privacy Practices

Acknowledgment of Receipt

I hereby acknowledge that I have received a copy of Montana Allergy PLLC Notice of Privacy Practices.

_____ Date:_____

Signature of patient or patient's representative

Printed name of patient _____

Printed name of patient's representative _____

Relationship to patient_____

USE/RESTRICTION OF PATIENT INFORMATION

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Montana Allergy is not required to agree to the patient's request, but if it does agree then the restriction is binding. The patient has the right to revoke the consent in writing, except to the extent that Montana Allergy has taken action in reliance on the consent. If this is the case, full upfront payment is expected as the information will not be shared with insurance companies.

I wish to be contacted in the following manner (check all that apply)

Telephone

- □ Cell: _____
- □ Home:_____
- □ Work:_____
  - □ O.K. to leave message with detailed information
  - □ Leave message with call-back number only

Written Communication

- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number _____

Verbal Communication

- □ O.K. to release information verbally to _____ _____ _____

All minors must be accompanied by an adult to appointments or shots unless otherwise authorized. The following adults are granted permission to discuss relevant issues about the patient's health:

1._____ 2._____ 3._____

The Privacy Rule generally requires health providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for Treatment, Payment, and Healthcare Operation (TPO) may be permitted without prior consent in an emergency.

Montana Allergy and Asthma Specialists: Financial Policies

We feel it is important that you understand our financial policies. Please read this carefully, and contact us with any questions.

Co pays/Deductibles
Office visit co-payments are due at time of service. Most co pay amounts are indicated on the insurance card. If you do not know your copay, and it is not indicated on the card, then we will bill your insurance first and upon receiving payment, we will bill you for the remaining allowable balance. For any deductibles, patients are responsible for any amount not covered by your plan.

Insurance Claims
To file any claims, we must have a copy of your current insurance information. If your insurances changes, you must provide us with the new information or you will be responsible for all the charges on your account.

Self-Pay Patients
You are responsible for payment of services. We offer a 20% discount to all patients that pay out of pocket. ***For all self pay patients, we expect 20% paid on date of service for office visits with the doctor.*** This does not include regular shot visits to the clinic.

No Shows/Late Cancellation
We provide numerous opportunities to remind you of your appointment via letters, postcards, and phone calls. Appointment cancellations must be made no later than 24 hours prior to the appointment. It is unlikely that we can fill last minute cancellations/no shows, and the doctor has reserved this slot for you. Please try your best to make your appointment at the slotted time. **Late Cancellations or "no shows" will be charged a $35 no show/late fee.**

Payment options: You may pay via the following options

1. Cash, Check, Credit (Visa, MC, American Express or Discover)
2. No Interest Payment Plans from CareCredit
    a. Allows you to pay over time with no interest (There are a number of different plans to fit your needs)
    b. Low monthly payment plans are also available
    c. No annual fees or pre-payment penalties
3. Other payment plan options available on individual case basis

***If it becomes necessary to send your account to a collection agency, you will be responsible for all collection and legal fees incurred.

Phone messages: Patient gives the right for Montana Allergy PLLC to leave phone messages regarding your account on voicemail/answering machine.

_____	_____	_____
Patient/Guardian Signature	Print Patient Name	Date

ALLERGY QUESTIONNAIRE

Patient Name: _____ Age:____ Date of Birth: _____ Sex: M__ F__

Ethnicity: ( ) Caucasian ( ) Hispanic ( ) Native American ( ) African-American ( ) Other

Your Physician (Name, Address and Phone #):

_____

_____

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY. Base your answers on your own observations and not on what others have told you or what you may have assumed on the basis of previous allergy tests. Please complete this form before seeing the allergist as the information will organize your thinking and help us to understand your problem.

What are the problems that bring you to an allergist?

_____

_____

Please indicate the symptoms you experience:

EARS	Yes	No
Itching	( )	( )
Fullness	( )	( )
Popping	( )	( )
Tubes placed	( )	( )
Hard of hearing	( )	( )
Frequent infections	( )	( )
# ear infections/year	_____	

THROAT	Yes	No
Soreness	( )	( )
Post-Nasal Drip	( )	( )
Itching of Palate	( )	( )
Recurrent Strep infections	( )	( )
Hoarseness	( )	( )
Tonsils	( )	( )
Adenoids removed	( )	( )

NOSE/SINUS	Yes	No
Repeated Sneezing	( )	( )
Watery discharge	( )	( )
Stuffy nose	( )	( )
Itching	( )	( )
Nasal trauma	( )	( )
Bloody nose	( )	( )
Poor sense of smell	( )	( )
Mouth breathing	( )	( )
Bad breath	( )	( )
Snoring	( )	( )

EYES	Yes	No
Contact Lenses	( )	( )
Itching	( )	( )
Burning	( )	( )
Watering	( )	( )
Swelling	( )	( )
Redness	( )	( )
Discharge	( )	( )
Glaucoma	( )	( )
Cataract	( )	( )

How many times a year are you treated with antibiotics for nasal/sinus infections? _____
For how long each time? _____
Date of last sinus x-rays? _____ Date of last CT scan of sinuses? _____

Date of any sinus surgery_____

CHEST	Yes	No
Cough	( )	( )
Wheezing	( )	( )
Sputum (phlegm)	( )	( )
Shortness of breath	( )	( )
at rest	( )	( )
with exercising	( )	( )
Coughed up blood	( )	( )
History of bronchitis	( )	( )
History of pneumonia	( )	( )
Positive TB skin test	( )	( )

Date of last chest x-ray: _____
Result: _____

Date of last pulmonary function studies: _____
Result: _____

SKIN	Yes	No
Eczema	( )	( )
Hives	( )	( )
Swelling	( )	( )
Infections (boils, impetigo)	( )	( )

Names(s) of skin soap(s)/shampoo(s)/moisturizers used? _____
_____
_____

Do you have problems wearing LATEX GLOVES or using latex products? (specify) _____
_____
_____

ASTHMA HISTORY

Have you ever been intubated, placed in intensive care, or on a respirator for asthma? _____
# of hospitalizations for asthma: _____ # of emergency room visits for asthma in the last year: _____
Number of courses of oral steroids (Prednisone/Medrol) taken for asthma in the past year: _____
Do you have a peak flow monitor? _____ What is your best peak flow reading: _____
# of times per month awakened with asthma (chest tight/wheeze/cough/short of breath) _____
# of times per week you need to use inhaler for acute asthma (beyond scheduled doses) _____
Is your asthma worse at school or work? _____

SEASONAL INCIDENCE

Please indicate your age when symptoms first appeared and check off the months in which the symptoms occur.

	Age of onset:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wheezing	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Coughing	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Nasal	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Eye	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Hives	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Eczema	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Other	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )

Are symptoms worse after exposure to:

( ) Raking leaves	( ) Humidity/heat	( ) Cigarette smoke	( ) Medications
( ) Lawn mowing	( ) Cold air	( ) Perfumes	
( ) Hay/compost	( ) Air conditioning	( ) Strong odors	
( ) Damp basement	( ) Weather changes	( ) Newsprint	
( ) Animals/Pets	( ) Smog (exhaust fumes)	( ) Foods	

ENVIRONMENT

How long have you lived in Montana? _____
Prior states(s)? _____
Type of home _____ How old is home? _____ How long lived there? _____
Location of home ( ) Country ( ) Suburb ( ) City
Basement ( ) yes ( ) no What is basement used for? _____
Is basement ( ) dry ( ) damp
Does anyone in home smoke? ( ) yes ( ) no
Who? _____ How much? _____

ANIMALS:

Do you have any pets? ( ) yes ( ) no
If yes, please list: _____
How long have the pets been with you? _____
Does the animal have full use of the house? ( ) yes ( ) no
Does the animal sleep on the patient's bed? ( ) yes ( ) no
Does animal exposure make symptoms worse? ( ) yes ( ) no

PATIENT'S BEDROOM:

Mattress		Pillow(s)	
Age: _____ years		Age: _____ years	
Type:		Type:	
Innerspring cotton	( )	Feather	( )
Foam	( )	Foam rubber	( )
Other _____		Synthetic	( )
		Buckwheat	( )

INSECT ALLERGY

After a bee sting do you have problems with:

	Yes	No		Yes	No
Local swelling	( )	( )	Hives	( )	( )
Tongue/Lip swelling	( )	( )	Swelling	( )	( )
Scattered hives	( )	( )	Shortness of breath	( )	( )

Have you ever been treated in an Emergency Room for an insect sting? _____ Date: _____

FOOD ALLERGIES/SENSITIVITIES: Do you have problems with any foods? If yes, describe problem. For instance: swelling or itching of tongue, lips, or mouth? Rashes or hives? Immediate or delayed vomiting or diarrhea?

Eggs _____
Wheat _____
Milk _____
Cheese _____
Shellfish _____
Tomatoes _____
Fish _____
Melon _____
Bananas _____
Walnuts _____
Peanuts _____
Soy _____
Others _____

DRUG ALLERGIES/SENSITIVITIES: Please list all medications to which you have had an adverse reaction and describe that reaction.

Medication Name	Approximate date and description of reaction

PATIENT HEALTH HISTORY: Have you had any of the following?

	Yes	No		Yes	No
High blood pressure	( )	( )	Diabetes	( )	( )
Heart disease or arrhythmia	( )	( )	Thyroid disease	( )	( )
Blood transfusion	( )	( )	Liver disease	( )	( )
Uncontrolled bleeding	( )	( )	Kidney disease	( )	( )
Dental problems	( )	( )	Arthritis	( )	( )
Cancer	( )	( )	Heartburn	( )	( )
Childhood Chicken Pox	( )	( )	Chronic diarrhea	( )	( )
Asthma	( )	( )			

Other ongoing medical problems? Please list:_____ _____

_____ _____

_____ _____

Surgeries: Please list procedure: Date:

_____ _____

_____ _____

_____ _____

Hospitalizations: Please list reason: Date:

_____ _____

_____ _____

_____ _____

MEDICATIONS: Please list **ALL** medications that you are currently taking, dosage, frequency, and for what condition(s).

Medication name/dosage	*Frequency*	*For what condition(s)*

IMMUNIZATIONS:

	Yes	No	Date(s)
Childhood series	( )	( )	_____
Hepatitis B	( )	( )	_____
Tetanus	( )	( )	_____
Pneumovax	( )	( )	_____
Chicken Pox Vaccine	( )	( )	_____

FAMILY HEALTH HISTORY

Does anyone in your family, **other than you**, have asthma, hay fever, hives, eczema?

	Yes	No	Who?		Yes	No	Who?
Nose & Eye Allergies (hayfever)	( )	( )	_____	Thyroid disease	( )	( )	_____
Food allergies	( )	( )	_____	Rheumatoid arthritis	( )	( )	_____
Stinging insect allergy	( )	( )	_____	Lupus	( )	( )	_____
Asthma	( )	( )	_____	Cystic Fibrosis	( )	( )	_____
Hives	( )	( )	_____	Sarcoidosis	( )	( )	_____
Eczema	( )	( )	_____	Tuberculosis	( )	( )	_____
Drug allergies	( )	( )	_____				

Any other chronic illnesses, (i.e., heart, lung, kidney) or diseases? _____

SOCIAL HISTORY

( ) Married ( ) Single ( ) Divorced ( ) Widowed

Occupation of patient: _____

Briefly describe workplace/school environment:

_____

_____

Number of days work/school missed in last year: _____

Does patient consume alcoholic beverages? ( ) yes ( ) no

If yes, type and frequency? _____

Does patient smoke? Current everyday_____
Current somdays_____
Former smoker _____
Never _____

If yes, how many packs/day? _____

Please list your hobbies and/or spare time activities:

_____

_____

_____

_____

_____