ALLERGY
AND ASTHMA ASSOCIATES

PEDIATRIC & ADULT ALLERGY, CLINICAL IMMUNOLOGY

Salmon S. Goldberg, M.D. • David S. Chudwin, M.D. • Kathy R. Sonenthal, M.D.
Irma M. Oliff, M.D. • J. K. Lawson, M.D.

PATIENT INFORMATION

_____ HOME_____PATIENT / PARENT
TITLE FIRST NAME MI LAST NAME

CELL _____ PATIENT / PARENT

OTHER PHONE_____BELONGS TO:_____

STREET ADDRESS CITY STATE ZIP CODE

E-MAIL ADDRESS _____

DATE OF BIRTH ____/____/_____ FULL TIME STUDENT YES / NO
MALE / FEMALE
MARRIED / SINGLE

Mother / Father / Spouse / Guardian
PERSON RESPONSIBLE FOR PAYMENT (full name)

_____ CELL / HOME / WORK
GUARANTOR'S MAILING ADDRESS AND PHONE IF DIFFERENT THAN PATIENT

OTHER FAMILY MEMBERS SEEING US _____ RELATIONSHIP _____

WERE YOU REFERRED TO OUR OFFICE? NO / YES BY:_____

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY _____

POLICY ID _____ GROUP NUMBER _____

PRIMARY SUBSCRIBER NAME: _____

PRIMARY SUBSCRIBER DATE OF BIRTH: _____

PLAN REQUIRES A REFERRAL [ ] YES [ ] NO [ ] DON'T KNOW

SPECIALIST CO-PAY $_____ [ ] NONE [ ] DON'T KNOW

SECONDARY

INSURANCE _____

POLICY ID _____ GROUP _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: _____

REQUIRES A REFERRAL _____

CO-PAY _____

TURN OVER

500 Skokie Blvd, Ste 140
Northbrook, IL 60062
(847) 272-4296

150 W. Half Day Rd, Ste 200
Buffalo Grove, IL 60089
(847) 793-0777

475 Brown Blvd, Ste 104
Bourbonnais, IL 60914
(815) 933-5092

300 Memorial Dr, Ste 250
Crystal Lake, IL 60014
(815) 455-7289

EMPLOYER INFORMATION

EMPLOYER _____ PHONE _____

ADDRESS _____

OCCUPATION: _____ Full Time / Part Time / Student / Unemployed

AUTHORIZATIONS AND AGREEMENTS

I _____, hereby give my consent to Allergy and Asthma Associates to use or disclose, for the purpose of carrying out treatment, payment or health care operations, my Protected Health Information.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I _____, hereby authorize Allergy and Asthma Associate, to use or disclose Protected Health Information (PHI) by releasing my medical records to my spouse, members of my family and/or a legal or personal representative, physician(s), or entity as indicated below. I understand that the person(s) and/or entity name on this authorization will be given access to obtain or review my records and has my permission to discuss my case or obtain results information on my behalf. This authorization extends only to the person(s) and/or entity I have identified below.

_____

NAME OF FAMILY MEMBER / REPRESENTATIVE RELATIONSHIP PHONE

_____

NAME OF PHYSICIAN ADDRESS

I _____, hereby authorize payment to be made directly to Allergy and Asthma Associates, for insurance benefits payable to me. I understand that I am financially responsible to Allergy and Asthma Associates for any covered and non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer, which are not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance, may be added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorneys' fees and other costs incurred for collection.

I _____, acknowledge access to the Privacy Notice for Allergy and Asthma Associates, which provides detailed information about how the practice may use and disclose my Protected Health Information.

SIGNED _____DATE_____

If you are not the patient, please specify your relationship to the patient.

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A typical new patient visit may involve:

Consultation	$180 - $325
Allergy testing	$396 inhalant panel
	$396 food panel
Breathing test	$ 80 for asthma

Tests are not included in the office visit.

Your insurance company can tell you whether these charges will be paid or will go towards your deductible. We do not have details on how your policy will cover our claim; you will be responsible for balances that insurance applies to your deductible.

If you have an HMO it is your responsibility to provide a valid referral to us.

I have read and understand the above.

_____ _____
Name Date

500 Skokie Blvd, Ste 140
Northbrook, IL 60062-2811
(847) 272-4296

150 W. Half Day Rd, Ste 200
Buffalo Grove, IL 60089-1782
(847) 793-0777

475 Brown Blvd, Ste 104
Bourbonnais, IL 60914
(815) 933-5092

5911 Northwest Hwy, Ste 208
Crystal Lake, IL 60014
(815) 455-7289

Allergy and Asthma Associates
Financial Policy and Credit/Debit Card Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. *I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.*
2. *Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.*
3. *This practice may deny service or charge a service fee for failure to pay a co-pay or any outstanding balance at the time of service.*
4. *It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.*
5. *I agree to provide the above practice and/or its designated payment agent with my debit/credit card information.*
6. *I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be stored independently by a Payment Card Industry (PCI) service provider in order to maintain the security of my payment information.*
7. *If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.*
8. *I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.*
9. *In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.*
10. *I will not be provided with advance notice of payments authorized hereunder for transactions up to a maximum amount specified by me. I will be provided with a courtesy notification prior to processing any payment in excess of such amount. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.*
11. *I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file.*

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be canceled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____ _____

Cardholder Name as it Appears on Card | Patient Name (if different from Cardholder)

_____

Cardholder Billing Address | City | State | Zip Code

_____ _____

Phone Number | Cardholder Email Address

_____ _____

CARDHOLDER SIGNATURE | DATE

Allergy and Asthma Associates
Credit Card on File Policy

Allergy and Asthma Associates has implemented a Credit Card on File program as a convenient method of paying for the portion of your services that your insurance policy requires you to pay such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure. This policy has been implemented to simplify and enhance your patient experience, and to simplify our business operations.

Q & A about Credit Card on File

How does this work? At patient registration we will ask you to sign a credit card on file agreement. As part of the agreement you will be able to set a maximum to be charged to your card. Charges that exceed this maximum require verbal authorization from the card holder prior to processing payments. At checkout, fees due at the time of service will be paid using the card on file unless you elect to pay by an alternative method.

What are the benefits to me? You can use your credit card on file to pay for copays, coinsurance, and deductibles at future visits. It will make checkout easier, faster, and more efficient.

What if I don't have a credit card? It is our policy that payment is due at the time of service. You may also keep your Health Savings Account (HSA) or Flex Spending Account (FSA) credit cards on file. If you do not have either of these types of cards, then you can use a debit or credit card. We accept Visa, Mastercard, American Express, and Discover.

How can I be assured that my credit card information will remain safe? We are under the strict rules and guidelines of Payment Card Industry (PCI) Compliance, and HIPAA Compliance to protect patient privacy and credit card information is considered protected health information. Our third party credit card processing vendor will store your information on a secure and encrypted site, which will enable us to run bank card transactions on our computer system. Our employees will not have access to your bank card.

Appointment and No Show/ Cancellation Policy

1. We attempt to accommodate patients' appointments by scheduling at their convenience. As a courtesy, we will remind you of your appointment by calling and/or texting/emailing you prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event that your mailbox is full or your line is busy our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients.

2. We request cancellations be done at least 24 hours prior to the scheduled visit. If you cancel less than 24 hours prior to your scheduled visit or are a no show, we reserve the right to charge a fee of $50.00. If you cancel the rescheduled visit, you will be charged another $50.00 fee. Please note that the $50.00 cancellation fee cannot be submitted to insurance and is the sole responsibility of the patient. Please make every effort to attend your scheduled visit.

_____ _____

Patient (or patient representative) acknowledgement Date

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Consent to Leave a Medical Message on phone/email

Patient Name _____ DOB _____

We will call you with your Lab, X-Ray or CT scan results, usually within one week from the date you had your test. If you have not heard from us within 10 days, please call our office.

To protect your privacy, please confirm who we can talk to regarding your results:

___ Patient only

___ Spouse (print spouse's name) _____

___ Parent or Guardian (print name) _____

(circle your answer)

May we leave normal results on your answering machine or voice mail: YES NO

Does this authorization include discussion of your office visits and medical history: YES NO

Home phone # _____

Cell phone # _____

Work phone # _____

Email: _____

X_____ Date _____

Signature of ____Patient _____Parent _____Guardian

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Crystal Lake, IL 60014
(815) 455-7289

Name_____ Date of Birth ____/_____/_____ Date _____/ _____/_____

Last Flu Vaccine (month/year) _____/_____ Pneumonia Vaccine? Yes No Covid Vaccine? Yes No (month/year)

Primary MD _____ #1___/____#2___/___#3___/____#4____/____ #5____/____

REVIEW OF SYSTEMS *(Circle current symptoms or check No Problems*)

Overall Health ___ No problems

Fever Chills Sweats Fatigue Unexplained weight loss / weight gain Failure to thrive (child)

Allergy/Immunology ____No problems

Recurrent infections Weight loss Seasonal allergies Food allergies Animal allergies Sting reactions

Ears, Nose, Throat ___No problems

Sneezing Runny nose Nose congestion Post Nasal drip Itchy nose/throat Nosebleeds Face pain

Sinus infections Snoring Ear infections Ear popping Muffled hearing Strep throat Hoarseness

Eyes ___ No problems

Itching Redness Watery Dry/gritty Swelling of lids Rashes of lids

Lungs ____No problems

Dry cough Cough with mucus Wheezing Chest tightness Chest pain Smoke exposure Past Covid 19 infection

Heart ___No problems

High blood pressure Irregular heartbeat Rapid beat Slow beat Swollen ankles Chest pain Murmur

Gastrointestinal ___No problems

Heartburn Stomach pains Nausea Vomiting Diarrhea Constipation IBS Difficulty swallowing

Blood/Lymph System ___No problems

Bruising Bleeding Anemia Low platelets Swollen glands History of mononucleosis

Endocrine ___ No problems

Diabetes Low blood sugar Thyroid disorder Heat/Cold intolerance Excessive Thirst / Hunger/Urination

Muscles, Bone, Joints ____No problems

Joint pain Joint swelling Muscle pain Osteoarthritis Rheumatoid arthritis Autoimmune disorder

Skin ___No problems

Eczema Hives Rash Itching Dry skin Blisters Poison ivy/oak Metal allergy Swollen lips/eyelids

Neurologic ___No problems

Headaches Migraine Dizziness Fainting Numbness Weakness Tingling

Psychiatric ___ No problems

Depression Anxiety ADD ADHD Insomnia Bipolar Memory changes

COMMENTS ON ANY OF THE ABOVE _____

_____

M.D. / R.N. INITIALS _____