IMPORTANT INFORMATION CONCERNING YOUR APPOINTMENT

Some medications may interfere with allergy testing therefore you MUST DISCONTINUE ANTIHISTAMINES 5 DAYS PRIOR TO YOUR APPOINTMENT. If you are being seen for hives, you CAN continue all of your medications.

On the day of your visit please be sure to bring your insurance card, copay (if applicable), a photo identification, insurance referral (if applicable), completed documents and a list of your current medications. In consideration of all patients who may be sensitive we request that you refrain from using scented lotions, oils, perfumes or colognes when visiting our office.

Plan on being here 2 to 3 hours – in this time you will meet the physician, have your testing when appropriate and receive your results all in one day, if possible. The first visit will be the most time consuming.

PLEASE call us 48 hours prior to your appointment if you are unable to make your appointment. This will allow us to offer the appointment to another patient.

Please call our office if you have any questions.

AUTHORIZATION TO BILL PATIENT INSURANCE
& PATIENT RESPONSIBILITIES

You have an appointment scheduled with Central PA Asthma and Allergy Care due to a specific allergy problem (asthma, sinusitis, hives, hay fever, insect sting allergy, eczema, food or drug allergies, headaches, etc.). Central PA Asthma and Allergy Care are specialty care physicians, and we must work in conjunction with your primary care physician (PCP) to provide you with your necessary medical management.

An allergic investigation includes a detailed history, physical examination, skin tests, and a thorough discussion, with all results, at the conclusion of the investigation.

It is the **responsibility of the patient** to make arrangements for all authorizations (if one is required) once an appointment has been scheduled with our office.

We will submit the charges to the insurance company(s) that we have on file for the patient. However, any **deductible, copayment, or non-covered service will be the responsibility of the patient.**

If after reviewing this information, there are additional questions, please contact our office at 814-944-2097 and ask to speak to the billing department.

Date:______________________ Patient Name:____

Patient Signature:____

Patient Social Security Number:____

Parent Signature (if patient under age of 18):____

Parent Social Security Number (if patient under age of 18):_______________________________

Parent Date of Birth (if patient under age of 18):____

I authorize consent to use and disclose information for treatment and healthcare operation purposes

Date:_______________ Patient's Name:____

Patient's Address:____

Patient's Phone Number(s):
_____________________(Cell) ________________________(Work)__________________(Home)

Please provide name(s) of person(s) to whom we may disclose personal medical information:

_______________________________________(relationship)_____________________(phone)

_______________________________________(relationship)_____________________(phone)

Patient's Primary Care Physician:____

Referring Physician:____

Other Physicians you want correspondence sent to:_______________________________________

Patient's Pharmacy:____
Patient's Signature giving authorization for e-prescribing consent: (this will allow CPAAC to electronically send all of your prescriptions to your pharmacy electronically)

____

I agree that CPAAC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. I hereby provide informed consent to CPAAC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Patient Name: ____

Reason for appointment/symptoms (Check all that apply):

__________ Environmental Allergies
__________ Food Allergies
__________ Asthma/Breathing Symptoms/Cough
__________ Venom/Bee Allergy
_________ Medication Allergy
_________ Skin Symptoms
_________ Immune Deficiency
_________ Others (please list)

Current Medications:

Medication Reactions (drug/symptoms):

Chronic Health Conditions/Diagnosis (treated or untreated):

Surgeries/Hospitalizations:

08182017