SOUTH BAY ALLERGY & ASTHMA ASSOCIATES

PRACTICE LIMITED TO PEDIATRIC AND ADULT ALLERGY & CLINICAL IMMUNOLOGY

BOARD CERTIFIED IN ALLERGY, ASTHMA & IMMUNOLOGY
EDWARD BUCHSBAUM, M.D., F.A.C.A.A.I
JOYCE SCHOETTLER, M.D., F.A.C.A.A.I
KATIE MARKS, M.D.

Welcome to our practice!

We are pleased to welcome you to South Bay Allergy & Asthma Associates and look forward to providing you with comprehensive allergy and asthma care.

Our staff and doctors make every effort to be timely and we do not double book your appointment time. In order to accommodate the scheduling needs of all patients, kindly confirm your appointment by phone at (310) 371 - 1388 x 11 or by email at least 2 business days prior to your appointment. appointments@southbayallergy.com

Appointment Cancellation and Rescheduling Policy
Notification to reschedule or cancel an appointment must be received in our office at least *two business days* prior to your appointment.
Failure to do so will result in a $50 fee.

Please be considerate of other patients. Do not eat/snack while in the office. Refrain from using scented lotions/perfumes when visiting our office as these may trigger reactions in some of our patients. Additionally, refrain from using your cell phone while in the office as it is distracting to our staff and other patients.

Please bring your insurance card and photo I.D. to your first visit. It is your responsibility to make sure that we have the most current insurance information on file for you. A statement will be sent to you only if there is an outstanding balance due after your insurance has paid its portion of the claim.

Co-pays, co-insurance and unmet deductibles are due at the time that services are provided. Please be prepared to take care of your financial responsibility at the time of your visit. You will be informed of your responsibility for skin testing prior to the procedure being performed.

Regarding emails: In an effort to be environmentally-friendly and medically efficient our office uses Electronic Medical Records and electronic reminders. Please provide us with an e-mail address so our staff can forward appointment confirmations and practice news alerts to you.

Obtaining diagnostic results: Please do not call the office to review or obtain lab results; these results will be reviewed at the time of your next visit with the doctor. Our nurses and office staff are not trained to interpret lab or radiology results.

Thank you for choosing South Bay Allergy & Asthma

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PATIENT INFORMATION (Please complete legibly)					
Name (Last, First, Middle]			Nickname/A.K.A.	Age	Birth Date
☐ Male ☐ Female Height: Weight:	Email			SSN# of Patient	
Home Street Address (P.O. boxes are not acceptable)			Primary Phone # ☐ cell ☐ home ☐ work		
City	State	Zip Code	Secondary Phone # ☐ cell ☐ home ☐ work		
Occupation	Employer		Employer Phone #		
Preferred Pharmacy Name	Preferred Pharmacy Address		Preferred Pharmacy Phone		
Race/Ethnicity ☐ White (Not of Hispanic origin) ☐ Black (Not of Hispanic origin) ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other:_____ ☐ Decline to state					

INSURED PARTY-- If not self				
Name (Last, First, Middle Initial)	Patients' Relationship to Insured	Birth Date	SSN# of Insured	
Home Street Address (P.O. boxes are not acceptable)	Primary Phone #			
City	State	Zip Code	Secondary Phone # ☐ home ☐ work	

PRIMARY INSURANCE INFORMATION			
Primary Insurance Company	Effective Date	Subscriber/I.D. #	Group #

SECONDARY INSURANCE INFORMATION (if applicable)			
Secondary Insurance Company	Effective Date	Subscriber/I.D. #	Group #

PRIMARY CARE PHYSICAN AND REFERRAL INFORMATION		
Name of Primary Care Physician	Name of Referring Doctor	**How Did You Hear About Us?** (If Other Than Doctor) ☐ Website/Search Engine (Please write URL): ☐ Family/Friend (Please include name): ☐ Insurance Company Referral

EMERGENCY CONTACT		
Emergency Contact Name (Last, First)	Telephone #	Relationship

FINANCIAL AGREEMENT- READ BEFORE SIGNING

RELEASE OF MEDICAL RECORD In order to ensure proper follow- up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and /or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION I authorize any holder of medical and other information about me to release to Medicare and its agents, an insurance company, any other third party payer, a state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of the authorization to be used in place of the original.

Signature_____ **Relationship to Patient** _____ **Date** _____

Patient or person authorized to consent for patient (If signing for minor)

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ENVIRONMENTAL SURVEY

1. What city do you live in? _____ Years in Southern California: _____
   Previous locations (give dates):_____

2. Do you live in a… ☐ *house* ☐ *condo* ☐ *apt* *or* ☐ *townhome*? How old is it? _____

3. Does vacationing out of state affect your symptoms? _____ Describe: _____

4. Any known water damage in home? _____ Any air filters in home? ____ Describe: _____

5. Number of pets at home: dogs: _____ cats: _____ birds: _____ rabbits: _____ other: _____
   a. Which pets are indoors? _____

6. Is the home near a/an… ☐ *open field* ☐ *refinery* ☐ *construction site* ☐ *airport* ☐ *other* _____

7. Please describe the patient's bedroom:
   a. Flooring: ☐ carpet (age:_____) ☐ hardwood floors ☐ tile ☐ other_____
   b. Window covering: ☐ blinds ☐ draperies ☐ curtains ☐ shades ☐ shutters ☐ other _____
   d. Bed(s): ☐ waterbed ☐ mattress (age:_____) ☐ bunk-beds
   h. Items in bedroom: ☐ stuffed toys ☐ books ☐ magazines ☐ dust collectors ☐ other_____
   i. Allergy proofing: ☐ allergy encasings ☐ HEPA filter

SOCIAL HISTORY

1. Occupation: _____. Describe any unusual work exposures:_____
2. Do you currently smoke? _____ Have you smoked in the past? _____ Years: _____ Packs a day: _____
3. Do any household members smoke in the home? _____ In the patient's bedroom? _____
4. Hobbies/sports: _____
5. Height:_____ Weight:_____

FAMILY HISTORY Please check all that apply for family history of allergies:

	Mother	Father	Siblings (list)	Other (list)	Describe
a. Nasal Allergies					
b. Asthma					
c. Eczema					
d. Hives					
e. Sinus Problems					
f. Immune Disorder					
g. Anaphylaxis					
h. Food Allergy					
i. Autoimmune Disease (i.e. Lupus, Rhumatoid Arthritis)					

Do any immediate family members have a history of the following? (Please check if yes):
a. ☐ Diabetes b. ☐ Heart disease c. ☐ Tuberculosis d. ☐ Hypertension e. ☐ Cancer, type:_____

REVIEW OF SYSTEMS Please check if you have any medical issues with the following:

	✓	Describe		✓	Describe
a. Hypertension			b. Diabetes/thyroid		
c. Gastrointestinal			d. Neurologic		
e. Joint/Autoimmune			f. Musculoskeletal		
g. Skin			h. Psychiatric		
i. Bladder/kidney			j. Cancer		
k. Heart Disease					

Patient Name: _____ Date: _____

Signature _____ Relationship to patient _____

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Notice of Privacy Practice

Can confidential messages (i.e. appointment reminders, lab results, x-ray results) be left on your telephone answering machine or voice mail? ☐ Yes ☐ No

Please list any family members or persons with whom we may leave messages:

Name	Relationship
Name	Relationship
Name	Relationship

When you ask us to fax information to you, it is your responsibility to make sure that the fax number is correct and your confidential information will not be read by anyone else.

You are fully aware that a cell phone is not a secure and a private line.

By signing below, you acknowledge that you have received a copy of this office's Notice of Privacy Practices and authorize all of the above information.

Patient's Name	**Date**
Signature (Guardian's if under 18 years)	**Relationship**

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ACKNOWLEDGMENT OF FINANCIAL POLICY

- I understand that is my responsibility to verify my insurance policy coverage prior to an office visit. Please be prepared to take care of your financial responsibility at the time of your visit. You will be informed of your responsibility for skin testing prior to the procedure being performed.

- **Payment of co-pays, deductibles, and co-insurance is due at the time service is rendered**. All services not covered or approved by the insurance carrier remain my immediate responsibility.

- If the physicians of SBAAA are not under contract with my insurance carrier, I understand that it is my responsibility to pay for that portion of services not covered by the plan policy.

- I understand that it is my responsibility to notify the business office of any change in my insurance coverage before an appointment date. If I fail to notify the office of a change in my insurance coverage, or the effective date of my new insurance, it is not likely that charges incurred after the effective date of the policy change will be covered and that I will be responsible for these charges.

- I understand that some insurance carriers require precertification for lab work done outside of the office (CT scans, x-rays and "blood work"). I understand that it is my responsibility to check with my insurance carrier prior to having the studies performed and to determine if a certain laboratory or x-ray facility must be used. (The SBAAA office will help you as much as possible with this information, please note that policy coverage for procedures performed outside of the office can change without our office being notified).

- Notification to reschedule or cancel an appointment must be received in our at least two business days prior to your appointment. Failure to do so will result in a **$50.00** fee.

- For Medicare patients only: I understand that the SBAAA physicians are Medicare providers and will submit all claims to my insurance carrier. I understand that I will be responsible for annual deductibles and applicable copays.

- SBAAA is not a MediCal contracted provider. If I elect to be seen by SBAAA I will be responsible for payment of service.

- For patients with HMO insurance only: I understand that my insurance will only pay for services if prior authorization has been obtained for each visit. If I choose to be seen by the physician without the necessary authorization, I understand that I will be responsible for 100% of the charges. I understand that it is not possible for SBAAA to obtain an authorization once the visit has been completed.

- For patients with a POS option only: I understand that if I elect to use my POS option, I must continue to use this option for all future visits. I understand that I cannot switch back to my HMO plan and expect to get authorizations for completed visits and procedures.

_____ _____

Signature (parent/guardian where applicable) Date

_____

Print name