IMPORTANT INFORMATION ABOUT YOUR APPOINTMENT

There are some very important items to complete prior to your appointment.

1. Bring current insurance card and photo ID the day of your appointment
2. If the patient has had previous testing, please bring these results with you the day of your appointment.
3. Plan to arrive 15 mins. prior to your appointment
4. Confirm the location of your appointment to be sure you are going to the correct office

In the event that skin testing is needed, all oral antihistamines or decongestant medications (such as most over-the counter cold remedies, sinus preparations, or allergy medicines, i.e. Benadryl) should be discontinued for 3 days before your visit. Please note that many over the counter sleep aids such as Tylenol PM, Advil PM, etc. contain Diphenhydramine which is an antihistamine. Review all medications taken to determine if an antihistamine is present. Asthma medications, nasal sprays and eye drops usually need not be avoided. Please note: If you are using Allegra, Atarax/hydroxyzine, Claritin and Alavert (Loratadine), Clarinex or Zyrtec, these medications must be discontinued for a full seven (7) days prior to your visit. Please visit our website at: www.allergic1.com for a full list of medications.

If your insurance company requires a referral from your primary care physician, please be sure you have arranged for this referral so it will be in our office prior to your visit. Payment for services, or your co-payment (if applicable), is expected at the time of your visit. If you require payment arrangements, these must be made with the Billing Department in advance of your appointment.

The initial evaluation usually requires 2 to 3 hours. Because we set aside this large block of time for you, we request at least 1 week notice should you be unable to keep your scheduled appointment*. Thank you.

Welcome to our office. Should you have any questions, please do not hesitate to call us at 513/793-6861. We look forward to your visit.

Staff of Allergy & Asthma Associates, Inc.

Please visit our Website for directions, maps, and other information:
www.allergic1.com

**Please be aware that if you no-show this appointment, you will be required to make a $200 deposit to reschedule*

MEDICATIONS PRIOR TO SKIN TESTING

The following medications may be taken as usual prior to skin testing:

Advair	**Famotidine**	**Mometasone**	**Pantoprazole**	Ranitidine
Alomide	Flovent	**Montelukast**	Pepcid	Rhinocort
Budesonide	**Fluticasone**	**Naphazoline**	Prednisone	Singulair
Cimetidine	Inhalers	Naphcon	Prevacid	Steroids
Crolom	**Lansoprazole**	Nasonex	Protonix	Veramyst
Cromolyn	**Lodoxamide**	Omeprazole	Pulmicort	

The following medications should be stopped 3 days prior to skin testing:

All over the counter antihistamines/ cough and cold preparations containing antihistamine				
Actifed	**Carbinoxamine**	**Dexbrompheniramine**	Meclizine	Rhinolar
Alka Seltzer	Cardec	**Dexchlorpheniramine**	Naldecon	Rondec
Allermax	Chlorafed	Dimetane	**Naphazoline**	Ru-Tuss
Allerest	**Chlorpheniramine**	Dimetapp	Nolamine	Ryaltris
Alloway	Chlor-Trimeton	**Diphenhydramine**	Novafed	Rynatan
Anafranil	Clemastine	Dramamine	Nyquil	Semprex
Antivert	**Clemastine Fumarate**	Dristan	Optimine	Sinarest
A.R.M.	Clistin	Drixoral	Ornade	Sine-Off
Astelin	**Clomipramine**	Dymista	Pataday	Sinubid
Astepro	Codimal	Epinastine	Patanase	Sudafed-Plus
Atrohist	Comhist	Extendryl	PBZ	Tavist
Azelastine	Contact	Fedahist	Pedia Care	**Tripelennamine**
Benadryl	Coricidin	Formula 44	Periactin	Triaminic
Bepreve	Co-Tylenol	Histalet Forte	Phenergan	Trinalin
Bonine	**Cyproheptadine**	Isochlor	Polaramine	**Triprolidine**
Bromfed	Dayquil	**Ketotifen**	Poly-Histine	Unisom
Bromodiphenhydramine	Deconamine	Kronofed-A	Promethazine	Zaditor
Brompheniramine	Demazin	Lastacaft	PV Tussin	

The following medications should be stopped 7 days prior to skin testing:

Please review your medicine list and consider stopping any of the following medicines 7 days prior to skin testing if possible. Only stop medicines if it is medically safe and tolerable to do so, this is especially true for certain psychiatric medicines which can cause severe withdrawal symptoms if they are stopped suddenly. In this case you should discuss with the prescriber. If you cannot stop medications for any reason we understand. The doctor can discuss testing options in more detail at your visit.

Allegra or Allegra D	Claritin or Claritin D	**Fexofenadine**	**Loratadine**	Xyxal
Alavert	**Cetirizine**	Hydroxyzine	Hydroxyzine	Zyrtec
Clarinex or Clarinex D	**Desloratadine**	Levocetirizine	Vistaril	

The following medications should NOT be stopped but will interfere with skin testing

Amitriptyline	Compazine	Imipramine	Perphenazine	Thorazine
Atarax	Desipramine	Limbitrol	Prochlorperazine	Tofranil
Chlorodiazepoxide	Doxepin	Norpramin	**Protriptyline**	Trifluoperazine
Chlorpromazine	Elavil	Nortriptyline	Stelazine	Trimipramine
Clomipramine	Fluphorazine	Pamelor	Surmontil	Vivactil

Revised 03/08/24

STEVEN A. SUTTON, M.D. ♦ JOHN A. ECKMAN, M.D.

ALLERGY & ASTHMA ASSOCIATES, INC. *513-793-6861*
10597 Montgomery Rd., Suite 200, Cincinnati, OH 45242
7144 Office Park Dr., West Chester, OH 45069

Date: _____ Physician being seen: _____

Patient's Legal Name: _____
Name you would like to be called: (Nickname) _____ Social Security #: _____
Date of Birth: _____ Sex: M or F Marital Status: Married Single Divorced Separated (Circle One)
Address: _____ Apt./Unit#: _____
City: _____ State: _____ Zip: _____
Home Phone #: (_____) _____ Cellular/Pager #: (_____) _____
Guardian 1/Relationship: (If patient is under 18) _____ DOB _____
Guardian 2/Relationship : (If patient is under 18) _____ DOB _____
Employer: _____ Work Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address (if available): _____ How did you hear about us? _____

Referring Physician: _____ Primary Care Physician: _____
Address: _____ Address: _____
Pharmacy Name: _____ Pharmacy Phone #: (_____) _____
Nearest Friend or relative: _____ Phone #: (_____) _____
Relationship to Patient: Spouse Parent Grandparent Daughter Son Friend Other: _____
(Circle one)
Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: Name of Insurance Company: _____
Is this Insurance an H.S.A.? _____ (Yes or No) Effective Date: _____
Insurance ID#: _____ Insurance Phone Number: _____
Name of Primary Person Insured: _____ Employer: _____
Social Security #: _____ Date of Birth: _____ Phone #: (_____) _____
Relationship to Cardholder: Self Spouse Parent Grandparent Other: _____ (Circle One)

Secondary Insurance: Name of Insurance Company: _____
Is this Insurance an H.S.A.? _____ (Yes or No) Effective Date: _____
Insurance ID#: _____ Insurance Phone Number: _____
Name of Primary Person Insured: _____ Employer: _____
Social Security #: _____ Date of Birth: _____ Phone #: (_____) _____
Relationship to Cardholder: Self Spouse Parent Grandparent Other: _____ (Circle One)

Is this injury related? ☐ Yes ☐ No Date of injury: _____
Type of injury: ☐ Motor Vehicle ☐ At Work ☐ Pedestrian ☐ Animal Bite ☐ Other: _____
Do you have injury related coverage information other than health insurance? ☐ Yes ☐ No

May we discuss your healthcare with someone other than yourself? ☐ Yes ☐ No
If yes, whom may we discuss it with: _____
Relationship to Patient: Spouse Parent Grandparent Daughter Son Friend Other: _____
(Circle one)

May we leave test results, etc. on your answering machine if you are not available? ☐ Yes ☐ No

Statement to permit payment of Medicare/insurance benefits to provider, physicians, and patient.
I authorize you to give me reasonable and proper medical care by today's standards. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers or other health insurance company any information needed for this or a related Medicare claim or other health insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accept assignment. I authorize and direct the health insurance company to issue payment check(s) directly to the physician(s) rendering the covered services. I understand it is mandatory to notify the health provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. I hereby claim the amount of indemnity specified in my contract with my health insurance company. I realize that I am responsible for all coinsurance, deductibles, and non-covered services/supplies billed to me by either entity listed above.

Signature: _____ Date: _____

STEVEN A. SUTTON, M.D. ♦ JOHN A. ECKMAN, M.D.

ALLERGY & ASTHMA ASSOCIATES, INC. *513-793-6861*
10597 Montgomery Rd., Suite 200, Cincinnati, OH 45242
7144 Office Pard Dr., West Chester, OH 45069

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be used/disclosed: Any chart information regarding allergies and/or asthma
Persons Authorized to use/disclose information: Staff of Allergy and Asthma Associates, Inc.

Persons/Organizations/Schools to whom information may be disclosed:

Name	Effective Until

Expiration Date of Authorization and Right to Terminate or Revoke Authorization:
This authorization is effective through the listed effective until date unless otherwise revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Allergy & Asthma Associates, Inc. Attn: Compliance Officer

Potential for Re-Disclosure:
Information disclosed under this authorization may be disclosed again by the organization or person to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Communication:
It is frequently necessary for personnel at this practice to communicate information regarding lab results, instructions, treatment, payment and other items of protected health information with our patients. In the event that we are not able to speak with you (the patient) directly, with whom may we communicate?

Name	Relationship to Patient	Phone

Where may we leave messages for you? (circle appropriate answer and write phone number):
At Home? Yes No @ _____ By Text? Yes No @ _____
On Cellular? Yes No @ _____ By Email? Yes No @ _____

In case of emergency while you are in our care, whom should we contact?

Name	Relationship to Patient	Phone 1	Phone 2

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time.

_____
Name of Patient Date

X _____
Signature of Patient or Patient Representative Relationship to Patient

Allergy & Asthma Associates, Inc. ------ *Steven A. Sutton, MD and John A. Eckman MD*

Patient History

Patient Name _____ Date of Birth ___/___/___ Date: _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow/er ☐ Child

Sex: ☐ M ☐ F Race: _____

Others living in home (please list names, ages and relationship to patient):

Primary Complaint (Why are you here?) _____

_____

Medications:

Do you have **any allergies** to drugs or medications? ☐Yes ☐ No **Are you allergic to Latex?** ☐Yes ☐ No

If yes, please explain: _____

List any **medications and dosage (prescription and/or herbal)** you are presently taking:

Past Medical History:

What signs or symptoms do you currently have: _____

Additional: _____

Additional: _____

Additional: _____

Additional: _____

Drug and Alcohol:

Have you ever used tobacco of any kind? ☐ YES ☐ NO If YES, type of tobacco: _____

At what age did you start using tobacco? _____

Do you smoke now? ☐ YES ☐ NO How many packs per day? _____

Do you drink Alcohol? ☐ YES ☐ NO Approximately how much per week? _____

Have you or do you use illicit drugs? ☐ YES ☐ NO If YES, type : _____

Prior Allergy Testing:

Have you ever had allergy testing? ☐ YES ☐ NO If YES, when? _____

Are you currently on or have you ever had allergy shots? ☐ YES ☐ NO If YES, when? _____

Have you ever had sinus or CT Scans? ☐ YES ☐ NO If YES, when? _____

Previous Surgeries:

Year	Surgery:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History: Who in your immediate family have had any of the following medical conditions:

allergies _____
asthma _____
hay fever _____
eczema _____
allergic dermatitis _____
hives _____

ROS: Do you currently have any of the following symptoms:

	Y	N		Y	N		Y	N		Y	N
fatigue	☐	☐	body swelling	☐	☐	anxiety	☐	☐	scarring/keloids	☐	☐
fever	☐	☐	seizure	☐	☐	depression	☐	☐	frequent infections	☐	☐
weight loss	☐	☐	joint pain	☐	☐	stress	☐	☐	diarrhea	☐	☐
eye pain	☐	☐	joint swelling	☐	☐	psychiatric problems	☐	☐	vomiting	☐	☐
chest pain	☐	☐	cold intolerance	☐	☐	lymph node enlargement	☐	☐	sleep problems	☐	☐
heart palpitation	☐	☐	heat intolerance	☐	☐	lymph node tenderness	☐	☐	bleeding problems	☐	☐
abdominal pain	☐	☐	weight gain	☐	☐	rashes	☐	☐	Blood in stool	☐	☐
difficulty voiding	☐	☐	weight loss	☐	☐	Chills	☐	☐	Other	☐	☐
Nail changes	☐	☐	Hallucinations	☐	☐	Tinnitus (ear ringing)	☐	☐			

Briefly comment on any of the above conditions which have been checked: _____

_____

Environment:

1. Do you have the following pets? ☐ Dog ☐ Cat ☐ Other: _____
2. Does anyone smoke? ☐ YES ☐ NO If yes, who? _____
3. Are you exposed to any unusual substances (chemicals, plastics, etc.)? ☐ YES ☐ NO
   If yes, please explain: _____

Lung:

1. Have you ever had a wheezing attack? ☐ YES ☐ NO
2. Have you had pneumonia? ☐ YES ☐ NO
3. Have you had bronchitis? ☐ YES ☐ NO
4. Do you cough frequently? ☐ YES ☐ NO

Nose: A. Please select the symptoms you have on a frequent basis:

☐ nasal congestion	☐ runny nose	☐ headaches	☐ itchy nose
☐ trouble hearing	☐ nose rubbing	☐ ear infections	☐ itchy ears/eyes
☐ trouble smelling	☐ nosebleeds	☐ head colds	☐ sneezing
☐ mouth breathing	☐ post nasal drip	☐ itchy throat	☐ sniffing

B. Have you ever had your tonsils/adenoids removed? ☐ YES ☐ NO
C. Do you have any problem tasting food? ☐ YES ☐ NO
D. Is your sense of smell impaired? ☐ YES ☐ NO
E. Have you ever had nasal trauma or a broken nose? ☐ YES ☐ NO

Skin:

A. Did you or have you had eczema /dermatitis? ☐ YES ☐ NO
B. Have you ever had hives? ☐ YES ☐ NO
C. Have you ever had swelling of your face, tongue, hands, or feet? ☐ YES ☐ NO

Food/Drug/Insect: Have you ever had an unusual or allergic reaction to any? ☐ YES ☐ NO
Have you ever had an unusual or allergic reaction to insect bites/stings? ☐ YES ☐ NO

If yes, please describe: _____

_____

_____

Physician Signature: _____ Date: _____

Allergy & Asthma Associates, Inc.

STEVEN A. SUTTON, M.D. ♦ JOHN A. ECKMAN, M.D.

ALLERGY & ASTHMA ASSOCIATES, INC. 513-793-6861

10597 Montgomery Rd., Suite 200, Cincinnati, OH 45242
7144 Office Park Dr., West Chester, OH 45069

Pharmacy Benefit Management (PBM) Consent for Allergy & Asthma Associates, Inc.

Allergy & Asthma Associates, Inc. uses ePrescribe technology to better update our EMR system with your health in mind. We are requesting consent for the following:

E-Prescribing – a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Medication history transactions – Provides the physician with information about medication the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

PBM's – are third party administrators of prescription drug program's whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing this consent form you are agreeing that Allergy & Asthma Associates, Inc. can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Patient Name (Printed) _____

Signature of patient / guardian _____

Date: _____ Relationship if other than parent: _____

Pharmacy: _____ Phone: _____

Pharmacy Address: _____

Consent Denied: _____ Date: _____

STEVEN A. SUTTON, M.D. ♦ JOHN A. ECKMAN, M.D.

ALLERGY & ASTHMA ASSOCIATES, INC. *513-793-6861*
10597 Montgomery Rd., Suite 200, Cincinnati, OH 45242
7144 Office Park Dr., West Chester, OH 45069

Statement to permit payment of Medicare/insurance benefits to provider, physicians, and patient.

I authorize Allergy & Asthma Associates, Inc. to give me reasonable and proper medical care by today's standards. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers or other health insurance company any information needed for this or a related Medicare claim or other health insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize and direct the health insurance company to issue payment check(s) directly to the physician(s) rendering the covered services. I understand it is mandatory to notify the health provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. I hereby claim the amount of indemnity specified in my contract with my health insurance company. I realize that I am responsible for all coinsurance, deductibles, and non-covered services/supplies billed to me by either entity listed above.

I have checked to be sure Dr. Sutton / Dr. Eckman are in my Network: Yes / No

I understand that if Dr. Sutton or Dr. Eckman are not in my Network, I will be responsible for payment.

Signature: _____

Date: _____

STEVEN A. SUTTON, M.D. ♦ JOHN A. ECKMAN, M.D.

ALLERGY & ASTHMA ASSOCIATES, INC. *513-793-6861*
10597 Montgomery Rd., Suite 200, Cincinnati, OH 45242
7144 Office Park Dr., West Chester, OH 45069

Patient Information
Patient Name: _____
Date of Birth: _____
Phone Number: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Please read and sign below to acknowledge your understanding of our financial policies.

1. Insurance Coverage
- I understand that **it is my responsibility** to provide accurate and current insurance and demographic information.
- I understand it is my responsibility to be sure that Dr. Sutton / Dr. Eckman are in my network.
- I authorize the release of medical information necessary to process my claims.
- I understand that **insurance verification is not a guarantee of payment**.

2. Co-Payments, Co-Insurance, and Deductibles
- I understand that **all co-pays are due at the time of service**.
- Any applicable **deductible or co-insurance amounts** determined by my insurance provider will be billed to me, and **I agree to pay these charges**.

3. Non-Covered Services
- I understand that my insurance may not cover all services, and I agree to be financially responsible for **any service not covered** by my insurance plan.
- I understand that there is a charge for completing forms for school/work/camp etc.
- I understand that there is a $75 charge for FMLA, 504 Plans, Disability forms or Specialty Letters

4. Self-Pay Patients
- If I am uninsured or choose to self-pay, I agree to pay all fees **at the time of service**, unless other arrangements have been made.

5. Billing and Payment Terms
- Statements are due upon receipt.
- **Balances not paid within 30 days** may incur late fees or be sent to a collection agency.

6. Missed Appointments / Late Cancellation
- I understand that cancellations must be made **at least 24 hours** before the appointment.
- I agree to pay a **no-show/late cancellation fee of $60** if I fail to do so.
- I understand that if I **no-show/late cancel** a New Patient appointment, I will be required to make a **$200 deposit to reschedule**.

7. Returned Checks
- I understand that a **$40 fee** will be charged for any returned check.

8. Authorization to Pay Benefits
I authorize insurance benefits to be paid directly to Allergy & Asthma Associates, Inc. for services rendered.

Acknowledgment and Signature

I have read and fully understand the financial policies above. I agree to comply with these policies and accept financial responsibility for all charges incurred.

Patient/Guardian Signature: _____

Print Name: _____

Date: _____