MICHAEL PARK, MD

LUCETTA LYFORD, PA-C

Park Allergy Center

Welcome to our practice!

- Please complete the enclosed questionnaire and bring it to your appointment.
- Obtain a copy of your medical record if you have been previously evaluated by an allergist.
- Your evaluation may include breathing tests and other specialized procedures in addition to your initial consult. Due to the expense involved, and the fact that some insurance plans do not provide coverage, we strongly suggest you contact your health insurance company to verify your plan covers allergy evaluations. You will be responsible for any charges your health insurance company does not cover.
- The estimated out-of-pocket cost for this visit is between $175-$225. We will be collecting your responsibility at check-in on the day of your appointment.
- Minors (up to 18 years of age) must be accompanied by a parent or guardian.
- Most initial appointments will take up to 45 minutes.
- For consideration of our patients and staff, we request you do NOT wear perfumes, colognes, and fragrant body lotions. Some of our patients have severe adverse reactions to these scents. Thank you for your understanding
- Please feel free to call us if you have any questions regarding the above, or if we can help clarify anything else prior to your appointment. Thank you for your cooperation.

Park Allergy Center

Rev 20181205

www.parkallergy.com 430 W. Centre Ave., Portage, MI 49024 (269) 321-6673 Fax (269) 324-5594

Drugs that block allergy skin tests

*This is not an all inclusive list. Please call our office if you have any questions.
Allergy Eye Drops - Must be off 7 days prior: Such as Patanol, Pazeo, Pataday, Zaditor, Ketotifen generic.
Allergy Eye Drops - Must be off 4 weeks prior: Optivar
Nasal Sprays - Must be off 4 weeks prior: Astelin, Azelastine, Astepro, Patanase, Dymista.
Muscle Relaxants - Must be off 2 weeks prior: Flexeril, Cyclobenzaprine
Steroids - Prednisone 10mg or less.

Antihistamines - Must be off 7 days prior:
Actifed Cold and Allergy
Alavert
Allegra, Allegra-D 12 hour, Allegra-D 24 Hour
Astelin - **Must stop 4 weeks prior to testing**
Astepro - **Must stop 4 weeks prior to testing**
Atarax
Benadryl
Bromfed, Bromfed-DM, Bromfed-PD
brompheniramine
cetirizine
Clarinex, Clarinex Reditabs, Clarinex-D 12 Hour, Clarinex-D 24 Hour
Claritin, Claritin Reditabs, Claritin-D 12 Hour, Claritin-D 24 Hour Chlor-Trimeton
chlorpheniramine, chlorpheniramine/pseudoephdrine
clemastine fumarate
cyprohepatadine
Deconamine SR
Dimetapp, Dimetapp Cold & Allergy Elixir
diphenhydramine
Dramamine
fexofenadine
hydroxyzine
Ibuprofen Cold & Allergy
loratadine, loratadine/pseudoephedrine
Motrin Cold & Allergy
Palgic
Patanase - **Must stop for 4 weeks prior**
pseudoephdrince/triprolidine
Rondec DM Drops, Rondec DM Syrup, Rondec Drops, Rondec Syrup Semprex-D
Tavist Allergy
Tussionex PennKinetic
Tylenol Cold & Allergy
Vistaril
Xyzal
Zyrtec

Welcome To Park Allergy Center
2020 PATIENT INFORMATION
*****PLEASE NOTE: If you are covered under your parent's, step-parent's or spouse's insurance no matter patient's age we must have your spouse's or parent's information to file insurance claims***

Last Name:________________ First Name:________________ Middle Initial:______

Preferred Name: ______________ Male ______ Female ______ Email:______________

Street Address: ______________________ City: ____________ State: ______ Zip:______

Birthdate: ____________ Age:______ Marital: single married widowed divorced

Home Phone: ____________ Cell: ____________ Work: __________ Circle which phone to leave messages: Home Cell Work

Employer: ______________ Occupation: ______________ Work Phone:____________

Primary Physician :________________ Referring Physician:________________

Emergency Contact: ________________ Phone:____________ Relationship:__________

Spouse Information

Spouse:________________ Birthdate ______________

Employer:________________ Phone #'s: Home:________ Cell: __________ Work: ________

*********Parent information - All patients under 18 must have both parent's information filled out***********

Father: ________________ Birthdate: __________ Married Single Divorced

Street Address: ______________________ City: ____________ State: ______ Zip:______

Employer: ________________ Phone#'s: Home:________ Cell: __________ Work: ________

Mother: ________________ Birthdate:__________ Married Single Divorced

Street Address: ______________________ City: ____________ State: ______ Zip:______

Employer: ________________ Phone #'s: Home: ________ Cell: __________ Work: ________

Please fill out step-parent's information if needed for insurance or contact information

Step-Parent: ________________ Birthdate: ______________ Is married to Father or Mother

Street Address: ______________________ City: ____________ State: ________ Zip:__________

Employer: ________________ Phone #'s: Home: ________ Cell: __________ Work: ________

Primary Insurance: Who supplies your Primary Insurance (please check one)
O My employer O Spouse's employer O Father's employer O Mother's employer O Step-Parent's employer O Self Insured

Primary Insurance:______________________ Subscriber ID#:________________ Group#:__________

Do you have secondary insurance? Please circle Yes or No If yes, Who supplies your Secondary Insurance (please check)
O My employer O Spouse's employer O Father's employer O Mother's employer O Step-Parent's employer O Self Insured
Secondary Insurance: ______________________ Subscriber ID#:________________ Group#:__________

I hereby authorize Park Allergy Center, PC to examine and treat me or my child and to perform such diagnostic tests as may be necessary for the duration of this illness. I hereby authorize the release of any medical information necessary to process my insurance claims. I understand the medical information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental disorders and or HIV serostatus. I hereby authorize for any benefits payable under my policy be paid directly to Park Allergy Center. Unless you specifically request a refund of any credit balance, all refunds and overpayments less than $25 will be applied as a credit on the patient's account and will be treated as unclaimed property under Michigan law if not used within three (3) years. All other credit balances will be refunded to you.
I understand that Park Allergy Center, PC collects all copays, coinsurance, deductibles and remaining balances when I check in at the front desk.
I understand that I am ultimately responsible for all charges, copays, deductibles, co-insurance and remaining balances not paid or covered by my insurance.

Signature of PATIENT (or Guardian):______________________________**Date:**______________

Guardian's Printed Name:________________________ **Relationship to Patient:**______________

Park
Allergy Center

THIS PAGE INTENTIONALLY LEFT BLANK!!!

Park Allergy Center

Michael Park, MD
Lucetta Lyford, PA-C

430 W Centre Ave
Portage, MI 49024

Phone: (269)321-6673
Fax: (269)324-5594

ALLERGY/ASTHMA QUESTIONNAIRE

How did you hear about us: (circle) Physician Referral Family/Friend Website Phonebook Other______

Name:____ Age:_____________ Appointment Date:_______________

Birthdate:_______________________Occupation/Place of Work:____

Please Circle: African American Asian Caucasian Hispanic Middle Eastern Other: _______________________

Describe the problem(s) you have been experiencing:____

____

____

Length of time you have had the problem(s):____

If you have been away from home in the past year, were symptoms better or worse while there? (Circle) Better Worse No Difference

Which season(s) bother your symptoms the most? (Circle)
All the time Spring Summer Fall Winter Changes of seasons

Previously evaluated by an allergist? (circle) Yes No **If yes, who and when:**________________________

____

Were skin test performed? (circle) Yes No **If yes, what were the results:**_______________________________

____

Have you ever received allergy shots before? (circle) Yes No **If yes, when did you start and end your treatment?**____

If yes, did you feel allergy shots were helpful? (circle) Yes No

ALLERGY HISTORY

Do you live in a (circle): House Apartment Condo Dorm Mobile Home Other____________________

Age of dwelling/Year built:____________________**Length of Occupancy:**____________________________________

Mattress (circle): Conventional Water Air Other__________________________**How old?** ______________

Pillow (circle): Feather Foam Dacron/Polyester Other_________________**How old?**________________

PATIENT NAME:_____________________

Animal Exposure at home or work: Cat _____ Dog _____ Horse _______ Other __________________

Ever been stung by a bee, wasp, hornet? (circle) Yes No **If yes, describe the reaction**________________________

Ever had poison ivy/oak/sumac? (circle) Yes No **Stuffy nose that worsens at night (circle)?** Yes No

Adverse reaction to medications (specify name/reaction):____

Adverse reaction to foods (specify food/reaction):____

Adverse reaction to latex or rubber:____

Adverse reaction to previous immunizations:____

Current medications:____

____

Past and current medical problems:____

____

Past surgeries:____

SOCIAL HISTORY

Who lives with you in your home (circle): Live alone Roommate Significant other Spouse Children Parents Siblings

Does anyone in your home smoke: Yes No

Patient's smoking status (circle): Current Former Never

Alcohol use (circle): Daily Weekly Monthly Yearly Never

Children (circle): Yes No **If yes, how many boys?**______________ **girls?**_______________

FAMILY HISTORY

Parents (circle): Seasonal/Animal Food allergies Asthma Eczema Other___________________

Siblings (circle): Seasonal/Animal Food allergies Asthma Eczema Other___________________

Children (circle): Seasonal/Animal Food allergies Asthma Eczema Other___________________

REVIEW OF SYSTEMS

Circle and describe any other problems not mentioned above

Eyes	Muscles/bones/joints	
Ear/Nose/Throat	Skin	________________________________
Heart	Neurological	
Lungs	Psychiatric	________________________________
Gastrointestinal	Hormonal	
Genital/bladder/kidney	Blood/lymphatic	________________________________

Park Allergy Center
Financial Policy

Thank you for choosing Park Allergy Center. We are dedicated to providing the finest healthcare for asthma and allergic diseases in children and adults.

Insurance Coverage: You, the patient, are ultimately responsible for your own bill and a clear understanding of your insurance policy. Patients who have healthcare coverage are responsible for providing our office with complete and accurate information regarding their insurance. We will need the primary policyholder's date of birth. We can not file your claim without this information. If you can not provide this information, you will be responsible for payment of all services rendered at your visit and you will need to file for insurance benefits on your own. It is your responsibility, not Park Allergy Center, to understand the terms of your insurance coverage. This includes but is not limited to: knowing what services are covered (allergy skin test, breathing tests, etc.), if your provider is in-network, your deductible, copayment, coinsurance, obtaining required referrals.

For the protection of our patients, in order to reduce medical identity theft, all patients are required to present a valid insurance card and driver's license at the time of service. If a driver's license is not available a valid photo ID must be presented.

We will file primary and secondary claims for you. We must have the explanation of benefits from the primary insurance claim in order to file secondary claims. We do not file tertiary claims.
We collect all copays, coinsurance, deductibles and remaining balances when you check in at the front desk. By signing this you understand that you are ultimately responsible for all charges, copays, deductibles, coinsurance and remaining balances not paid or covered by your insurance.

Self-Pay Patients: Patients without health insurance coverage are expected to pay their bill in full at time of service. For your convenience, we accept cash, check and Visa, MasterCard or Discover.

Nonparticipating Insurance Plans: If Park Allergy Center does not have an existing contract with your insurance plan, you will be responsible for the full amount billed.

Billing Separate Entity: If your employer or other entity is paying for your medical services, you will be liable should the employer or other entity not reimburse Park Allergy Center for the services rendered.

New vs Established Patient: Per AMA coding guidelines, a new patient is one who has not received any professional services from the physician or another physician of the exact same specialty who belongs to the same group, within the last three (3) years.

Office Visits/Procedures/Vaccines: Our office will verify your insurance benefits, to determine how much they say is your responsibility prior to your appointment, procedure and/or vaccine being made. We will collect all copays, coinsurance, deductibles and remaining balances when you check in at the front desk and prior to making your vaccine.

Shipping: You, the patient, is ultimately responsible for all charges related to shipping or transporting vials or other items, including replacement of missing or damaged vials or items.

Referrals: If your insurance policy requires a referral, you are responsible to see that a referral is obtained and provide that referral to our office.

Fees and Services Provided: Each patient's insurance coverage is different. If you have a concern regarding our fees, it is your responsibility to ask prior to the service being performed. There will be a charge for the provider's evaluation and separate charge for any service/procedure performed. Charges for services provided are subject to change without notice.

Refunds: We will make best efforts to refund overpayments to the appropriate party within 30 days. Patient refunds will not be processed until all active or past due accounts for patients or dependents are paid in full. Unless you specifically request a refund of any credit balance, all refund and overpayments less than $50 will be applied as a credit on the patient's account and will be treated as unclaimed property under Michigan law if not used within three (3) years.

Past Due Accounts: If your balance remains unpaid your account may be referred to a collection agency. If your account is at a collection status, the balance will need to be paid in full prior to your next visit.

Minor Patients: All patients below the age of 18 must be accompanied by a parent or guardian to receive treatment. Minors who are 16 years old and older may receive allergy shots without the parent's presence if the parent/guardian has given signed permission.

Child Custody: The parent or legal guardian that presents the minor for care and authorizes treatment will be the one who receives the bill for services provided and is responsible to see that the balance is paid.

Appointments: We require 24 hours (1 business day) notice to cancel or reschedule office visits. This allows us to fill our schedule with another patient. Appointments cancelled or rescheduled less than 24hours (1 business day) will be charged a $10 fee. If you cannot keep your appointment, please call our office to avoid a $35 fee. Fees must be paid before your next appointment. You may be dismissed from the practice if you have three (3) No Show appointments. Arriving late for an appointment may require you to reschedule. Continued late arrivals may result in dismissal from the practice.

Completion of Forms: Providers are often asked to complete a variety of forms outside of your visit. Completing these forms require time from the provider's day to review the chart and complete the forms accurately. Therefore, we charge a $5-$20 fee for this service per form, which must be paid prior to the forms being filled out. (Fee is subject to change)

NSF Fee: If your bank returns your check payment to us due to insufficient funds in your account, we will charge you an NSF fee of $25.

Medical Records Fee: We transfer medical records to other physicians at no charge. A charge based on the Michigan Medical Records Access Act will be applied for all other requests, including personal use.

PRINTED Name of PATIENT:____

____

PRINTED Name of Parent/Guardian, if patient is under 18 Relationship to patient

____

SIGNATURE of Patient (or Parent/Guardian) Date

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

____

Effective Date 01/01/2018　　　Publication Date 01/01/2018

Park Allergy Center
Form Number 7.20a

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

____

Name of patient

____

Signature of patient or personal representative

____

If signed by personal representative, relationship to patient

____

Date

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

. □ Refused to Sign □ Physically unable to sign

(Other)____

____

____

Employee Signature:________________________________ Date:______________________

Park Allergy Center
430 W. Centre Ave.
Portage, MI 49024

Michael Park, MD   Lucetta Lyford, PA-C

Authorization to Share Medical Information

Patient Name: ______________________________ Date of Birth: ___________

☐ I authorize Park Allergy Center to share my:

- ☐ Personal and/or demographic information
- ☐ Medical Information – excluding ________________________________
- ☐ Billing/Financial/Insurance Information
- ☐ All Information

To the following individuals:

______________________________	____________________
Name	Relationship to Me
______________________________	____________________
Name	Relationship to Me
______________________________	____________________
Name	Relationship to Me
______________________________	____________________
Name	Relationship to Me

--OR--

☐ I do not authorize Park Allergy Center to release any of my medical information to anyone, with the exception to benefits (i.e. insurance) or continuation of care (i.e. referrals).

This authorization will remain in effect until revoked in writing by the above listed patient.

______________________________ ____________________
Signature Date