



Baz Allergy, Asthma & Sinus

7471 N. Fresno St. Fresno, CA 93720
Phone: (559) 436-4500 Fax: (559) 261-1526

Center

Thank you for choosing our practice for your asthma and allergy needs. We are committed to the success of your treatment and care. We have seven offices to serve the needs of our patients.

- **FRESNO** 7471 N. Fresno Street. Fresno CA 93720 Phone: (559) 436-4500
- **MADERA** 2311 W. Cleveland Ave., Madera CA 93637 Phone: (559) 674-0075
- **CLOVIS** 1420 Shaw Ave. #105, Clovis CA 93612 Phone: (559) 325-9990
- **HANFORD** 1560 W. Lacey Blvd. #103, Hanford, CA 93230 Phone: (559) 582-8500
- **OAKHURST** 40232 Junction Drive, Oakhurst, CA 93644 Phone: (559) 642-2500
- **VISALIA** 205 S. West St. Suite D, Visalia, CA 93291 Phone: (559) 713-1600
- **CLOVIS NORTH** 2021 E. Herndon 2nd Floor, Clovis, CA 93611 Phone: (559) 292-8700

We have scheduled your appointment in our _____ office on ___/___/___ at ___:___ am/pm
If you are unable to keep this appointment, please call our office to reschedule. **24-HOUR NOTICE WILL BE APPRECIATED.**

To expedite your visit we have enclosed forms, which will need to be completed by you. Please bring the completed forms and your insurance card with you to your appointment. To help the doctor provide you with the best possible diagnosis of your condition the patient's history needs to be completed thoroughly.

In order to save you time and avoid inconvenience, we anticipate **allergy testing** may be involved during this visit. Please be aware that your first visit may take up to two to three hours. If this appointment is not for a child we strongly suggest that children not accompany you. Allergy testing requires the patient to be perfectly still and we have found that patients with children are unable to do this. **DO NOT TAKE ANTIHISTAMINES 4 Days PRIOR TO YOUR VISIT.** Enclosed you will find a list of medications to avoid. If these medications are taken we will be unable to do any allergy testing. Asthma medication, as well as other medications may be continued. **Please bring all medications (or a complete list) you are currently taking to your appointment.**

About Your Insurance Coverage:

If we participate with your plan, we will accept the appropriate co-pay at the time of service. We will file your insurance claim for you. Please be aware that some allergy services may not be a covered benefit under your plan. In this case, all non-covered services are your responsibility to pay in full the day services are provided.

When Payment is Due:

As stated above, charges not covered by your insurance are due at the time of service. We accept cash, checks, VISA, MasterCard and Debit cards.

Minor Patients: The parent or guardian accompanying a minor is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied.

If you have any questions regarding these instructions, or if you have any concerns, do not hesitate to call.

We look forward to seeing you,
BAZ ALLERGY, ASTHMA & SINUS CENTER

ANTI-HISTAMINES TO BE STOPPED FOR POSSIBLE ALLERGY TESTING:

Stop **FOUR** days before testing:

Actagen	Deconamine	Phenergan
Actifed	Dimenhdrinate	Poly-histine
Acrivastine	Dramamine	Promethazine
Allegra (any)	Dimetane	Rondec
Allerfrin	Dimetapp	Rynatan
Allerx	Diphenhydramine	Ryna-12
Antivert	Drixoral	Rynatuss
Atarax	Duravent-DA	Semprex-D
Benedryl	Fexofenadine	Tanafed
Bromphed	Histavent-LA	Tavist
Brompheniramine	Histex	Triaminic
Cetirizine	Hydroxyzine	Triaminicol
Chlorpheniramine	Loratadine	Trinalin
Chlor-trimeton	Meclizine	Tripolidine
Clarinox	Omnihist-LA	Tussi-12
Claritin (any)	Ornade	Tussionex
Clemastine	Pediacare	Vistaril
Cyroheptadine	Periactin	Zyrtec (any)

NASAL SPRAYS:

Astelin
Azelastine

EYE DROPS:

Azelastine
Patanol
Olopatadine
Optivar
Zaditor

ALSO: Any medicine that has the words **SINUS, ALLERGY, "HIST" or HISTAMINE**

Please advise the patients the following: Many over the counter medications have allergy medicine in them (i.e. sinus, headache, sleep or cough medicines). These medications will need to be stopped 4 days prior to the visit as well. If you are not sure if the medicine you are taking contains an antihistamine, please call the office for advice. **DO NOT** stop any other medications for heart, liver, lung or other conditions. If for some reason you cannot stop the allergy medications then don't. We will see you for the consultation and then appropriate testing can be done at a later date.

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DO NOT TAKE ANY ANTIHISTAMINES, IF POSSIBLE, FOR 72 HOURS BEFORE YOUR FIRST VISIT. CONTINUE THE REST OF YOUR MEDICATIONS

Name: _____ Age: _____ Sex: M / F Date: _____

Occupation / Job Description: _____ DOB: _____

Address: _____ Phone# _____

Hobbies: _____

Family Doctor: _____ Who Referred You To Our Office?: _____

Doctor's Seen In The Past: _____

Primary Reason For Seeing Us Today? Allergies Asthma Sinusitis Headaches Cough Hives Eczema

Other: _____

Previous Allergy Evaluation:

Have You Ever Seen An Allergist? Y / N (Name? _____)

Have You Ever Had An Allergy Skin Testing? Y / N

Have You Ever Received Allergy Injections? Y / N

If YES, Were Injections Helpful? Y / N

Nose / Eyes: ALL YEAR SEASONAL

When Do You Have These Symptoms?

Check Symptoms	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Runny Nose												
Stuffy Nose												
Sneezing												
Post Nasal Drip												
Itchy Eyes/Nose												

Please Check All That Trigger Or Make Your Allergies Worse

Allergens		Irritants	
Freshly Mowed Grass	Molds	Smoke	Fumes
Dead Grass	House Dust	Perfumes	Windy Days
Hay	Cats	Soaps	Cold Days
Flowers	Dogs	Cosmetics	Damp Days
Flower Pollens	Feathers	Cleaning products	Humidity
Trees		Paint Fumes	Alcoholic Beverages
Tree Pollens		Hair Spray	Spicy Foods
Weeds		Outside Dirt	

Head: Headaches Facial / Sinus Pain

Sinus X-rays Done? When: _____ Where: _____

Other Symptoms: _____

Ears: Popping Of Ears Ear Aches Ear Tubes

Other Symptoms: _____

DOCTOR'S USE ONLY (PLEASE DO NOT WRITE IN THIS AREA)

Historian?
 Patient Other _____

How Long?

Perennial Seasonal

Spring Summer

Fall Winter

Severity: Mild Mod. Severe

Frequency: _____ x wk / month

Nausea Vomiting
 Diplopia Nose

Chest: ALL YEAR SEASONAL

Do You Wheeze? Y / N When You Get A Cold?
 At Night? When Exercising?
 When Exposed To Cold Air?

Do You Cough? Y / N At Night? When Exercising?
 When Exposed To Cold Air?

Productive Cough? Y / N Color? Clear Yellow Green Brown
How Long Have You Had This Cough? _____
How Many Months Of The Year Do You Have This Productive Cough? _____

DOCTOR'S USE ONLY

How Long?
 Perennial Seasonal
 Spring Summer Fall Winter
 Cough Wheezing Chest Tightness
Nocturnal Symptoms? Y / N
Frequency: _____ x day / wk / month
Beta Agonist Use?
Frequency: _____ x day / wk / month
Use in last _____ day(s) / wk(s)
Any Hospitalizations for Asthma? Y / N
If yes, when was the last time?

When Do You Have These Symptoms?

Check Symptoms	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wheezing												
Cough												

Chest X-rays Done? When? _____ Where? _____
Have You Ever Been Diagnosed With Chronic Bronchitis? Y / N
Have You Ever Been Diagnosed With Emphysema? Y / N

Skin Problems: None

Eczema? How Long? _____
 Hives? How Long? _____
 Any Problems with Rubber or Latex Materials? Y / N
 Other Skin Diseases or Symptoms? _____

Food Allergy / Stomach Problems:

Gas? Cramps? Diarrhea? Other? _____
Which Food(s) and What Kind Of Reactions Do You Have? _____

Insect Allergy:
Have you ever had an allergic reaction to an insect bite? Y / N
If YES, Please Check All Insects That Have Triggered An Allergic Reaction

Honey Bee Yellow Jacket White Faced Hornet
 Wasp Kissing Bug Other Insects

Environmental:	INSIDE	OUTSIDE	SLEEPS IN BEDROOM
CATS:			
DOGS:			
OTHER:			

Past Medical / Surgical History:

Please List Illnesses / Surgeries You Have Had In The Past

Family History:**DOCTOR'S USE ONLY****Please Check If Any That Apply To Family Members**

	Hay Fever	Asthma	Eczema	Sinus Problems	Other Allergies
Brother(s)					
Sister(s)					
Mother					
Father					
Maternal Gr. Parents					
Paternal Gr. Parents					

Please List Any Family Diseases:

Female Patients:Are You Taking Birth Control Pills? **Y / N**Do You Have Regular Menses? **Y / N**

If YES, When Was Your Last Menstruation? _____

Are You Pregnant? **Y / N****Housing:****Please Check If Any That Apply To You**

Where Do You Live?

- Apartment Rural
 House Urban
 Mountain

Describe Your Work Place Environment? _____

Do You Use A Blanket? **Y / N** How Often Is It Washed? _____**Please Check If You Have These Things In Your Residence**

- Feather Pillows Humidifier Central Air / Heating
 Feather Comforters Dehumidifier Swamp Cooler
 Stuffed Toys Indoor Plants Wood Burning Stove
 Carpeting Hepa Filter System
 Book Cases

Is There Anything Near Your Home
That Might Pollute The Air or Water **Y / N****Marital Status:**
 Single Married Separated Divorced Widowed
Any Children? **Y / N** If YES, How many? _____

Please List Their Names:

Form Completed By Whom? _____

Relationship: _____

What Do You Expected From Your Allergist? _____



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Phone: (559) 582-8500 Fax: (559) 584-9133

□ 2311 W. Cleveland Ave., Madera CA 93637
Phone: (559) 674-0075 Fax: (559) 673-6058

□ 40232 Junction Drive, Oakhurst CA 93644
Phone: (559) 642-2500 Fax: (559) 642-2888

□ 205 S. West St. Suite D, Visalia CA 93291
Phone: (559) 713-1600 Fax: (559) 713-1602

□ 2021 E. Herndon 2nd Floor, Clovis CA 93611
Phone: (559) 292-8700 Fax: (559) 324-8748

FINANCIAL POLICY

Our continued participation in your health plan depends upon everyone fulfilling their obligation in accordance with the contracts. Patients are responsible for all deductibles, co-payments, coinsurance and non-covered charges. As a service to our patients, we call your insurance to get a description of benefits. This office is not responsible for incorrect benefit information given to us by your insurance carrier, or changes in coverage after verification date. A description of benefits is not a guarantee of coverage and cannot be relied on as such. In the event of non-payment by your insurance company the charges on your account will be your responsibility. Payment is due at the time service is rendered. We accept Visa, MasterCard, Discover, American Express, Personal Checks and Cash for your convenience. If you want to verify the insurance benefits quoted yourself, please call your insurance company.

PATIENT CONSENT: I hereby give consent for such medical treatment for myself or I am duly authorized by the patient and his/her general agent to consent for such treatment.

ASSIGNMENT OF BENEFITS: I hereby authorize payment for medical benefits directly to the provider of the services rendered.

RELEASE OF INFORMATION: I hereby authorize the release of any medical information necessary to process any insurance claims.

Patient Signature: _____ **Date:** _____
(If patient is under 18 parent or guardian must sign)

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out Treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceeding; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

PRINT NAME _____ **SIGNATURE** _____

DATE _____

Patient Name:	Account Number:
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MEDICAL INFORMATION RELEASE

This is to advise you that I have given authorization to Baz Allergy, Asthma & Sinus Center to provide any and all necessary information regarding my medical care to the following individuals below. This authorization is effective until terminated in writing.

Name (print) Relationship to Patient

Name (print) Relationship to Patient

Name (print) Relationship to Patient

Signature of Patient

Date

EMERGENCY PHONE NUMBERS

Name (print) Work Home Cell Relationship to Patient

Name (print) Work Home Cell Relationship to Patient

Name (print) Work Home Cell Relationship to Patient

Signature of Patient

Date