Berkshire Allergy Care

Thomas B. Edwards, M.D., FACP

Dear ______________________________

Your allergy evaluation appointment is on ______________ at ____________.
Prior to your arrival, please see that the following is accomplished:

1 – Please read the patient information sheet
2 – If lab work, chest x-rays, or sinus x-rays have been performed, please bring the report(s) with you
3 – Please provide a list of your medication(s) with the completed questionnaire
4 – Please call for the appropriate referral paperwork from your primary care physician

Your initial consultation could last approximately 60-90 minutes.

Although we cannot guarantee that we will be able to skin test you on the same day as your initial consultation, there may be an opening in the schedule that would allow testing to occur. **However, in order to have a skin test, you must refrain from taking antihistamines prior to testing. Some common medications are listed below.** Please call the office if you have any questions about medications that may interfere with skin testing.

To be skin tested, please refrain from taking the following for **7 DAYS**: Abilify, Amitriptyline, Antivert, Atarax, Cyproheptadine, Doxepin, Geodon, Hydroxyzine, Lamotrigine, Lamictal, Meclizine, Mertazapine, Nortroptyline, Periactin, Promethazine, Remeron, Risperidone, Seroquel, Sinequin, Turmeric Curcumin, Zyprexa

To be skin tested, please refrain from taking the following for **6 DAYS**: Clarinex

To be skin tested, please refrain from taking the following for **4 DAYS**: Alavert, Allegra, Allegra-D, Cetirizine, Claritin, Fexofenadine, Loratadine, Xyzal, Zyrtec

To be skin tested, please refrain from taking the following for **2 DAYS**: Allergy Eye Drops, Astelin, Astepro, Axid, Benadryl, Cimetidine, Diphenhydramine, Mylanta AR, Olopatadine, Over The Counter Antihistamines, Over The Counter Cold Medicines, Patanol, Pepcid, Ranitidine, Rynatan 12, Tagamet, Zantac

Some over the counter cold and allergy medications may contain antihistamines. Please consult your pharmacist if you have any questions

Patient Information

It is the desire of this office to provide you with the finest allergy care available. We will try to do this in a friendly, efficient, and economical manner. We will appreciate any suggestions you may have to improve our services.

369 South Street, Pittsfield, Massachusetts 01201 • (413) 443-4826 • fax (413) 443-4488

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Appointments

Scheduled appointments should be kept. If you are unable to make your appointment, please let us know in a timely manner, so the time may be offered to another patient. Check-ups are required at a minimum of once a year.

Your Physician

Dr. Thomas B. Edwards, M.D., is a physician with subspecialty training in allergic disease and asthma. He is a diplomat of the American Board of Allergy and Immunology. He is a fellow of the American Academy of Allergy, Asthma, and Immunology, the American College of Allergy, Asthma, and Immunology, and the American College of Physicians. He is the former Director of Allergy and Asthma Center of Albany College.

Your Initial Visit

Most patients come to this office by referral from the pediatrician or primary care physician. The purpose of this visit is to obtain a detailed history, adequate physical examination, allergy testing, and lab work necessary to establish whether allergy treatment is indicated.

Allergy Injection Treatment

If it is necessary for you to take allergy injections, your program will be outlined at the time of your visit. The usual routing is one or two shots per week, for approximately six months, to allow rapid build-up of the extract concentration. After your maintenance concentration is achieved, the interval between injections will then be lengthened to every two weeks, every three weeks, and then every four weeks. The duration of the injection therapy varies, but one should anticipate a 3-5 years program.

You may receive these injections at our office, or at your primary care physician's office. It is necessary to remain in the office for 20-30 minutes after receiving your injection, and be checked for reactions before leaving the medical office.

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Cost

The following insurance companies will be billed, if you are covered under the following plans:

1. AARP
2. Aetna
3. Blue Cross Blue Shield **(referrals are needed from the primary care physician for HMO plans)**
4. BMC Health Net
5. CDPHP
6. CeltiCare
7. Champ VA
8. Children's Medical Benefit
9. Cigna
10. Fallon Community Health Plan **(referrals may be needed from the primary care physician)**
11. Fallon Health & Life Assurance Plan
12. GIC Indemnity
13. Harvard Pilgrim Health Care **(referrals may be needed from the primary care physician)**
14. Health New England
15. Humana
16. Medicare
17. MassHealth **(referrals are needed from the primary care physician for PCC plans)**
18. MVP Health Plan
19. Neighborhood Health Plan **(referrals may be needed from the primary care physician)**
20. Tricare
21. Tufts Direct Plan **(referrals may be needed from the primary care physician)**
22. Tufts Health Plan **(referrals are needed from the primary care physician for HMO plans)**
23. Unicare
24. United Health Care
25. WPS Health Insurance

You will receive an itemized statement showing the transactions of your account, monthly. You will be responsible for copayments at the time of service. If you are unable to pay your bill in full, please contact the office and we will assist you in outlining an acceptable payment schedule.

If there is a mistake in your bill, please notify us immediately.

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PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Date of Initial Visit________________

Last	First	Middle	Birth Date	Age	Birth Place

Address	City	State	Zip	Home Phone	Business Phone

Occupation	Occupation Spouse	Medicare No.	Medicaid No.	Marital Status	Religion
				M F S M W D Separated	A C J P

Insurance Company ________________________________

Insurance Numbers Group No. ________________ Certificate No.________________

Person to Notify ________________________________

Address________________________ Relationship________________

Date of Last Ob.Gyn Exam ________________ Phone Number________________

Date of Last Complete Physical Exam ________________ Doctor________________ Town________________

Doctor________________ Town________________

Family Physician ________________ Address________________ Town________________

Referring Physician ________________ Address________________ Town________________

I would like a report of this consultation sent to doctor ________________ Town________________

What is your chief complaint ________________________________

Onset at age ________________

Circle "Yes" or "No"

Yes No Do you frequently have severe headaches?
Yes No Do they occur on one side of the head? Which side? R.________ L.________
Yes No Do they awaken you at night from sleep?
Yes No Do they feel like a tight hat band?
Yes No Do they hurt most in the back of the head and neck?
Yes No Do they hurt most in the front of the head, forehead or sinus area?
Yes No Does aspirin relieve them?
Yes No Do you frequently have excess tears in your eyes?
Yes No Do you have frequent ear aches?
Yes No Have you ever had a punctured ear drum or draining ear?
Yes No Do you now have decreased hearing?
Yes No Are you frequently hoarse?
Yes No Do you frequently get sore throats?
Yes No Do you frequently have stuffy nose?
Yes No Do you frequently have mucus in the back of your throat?
Yes No Have you ever had nasal polyps?
Yes No Do you wake up in the middle of the night short of breath?
Yes No Do you wake up coughing first, -- then wheeze?
Yes No Do you wake up wheezing first, -- then cough?
Yes No Do you cough up mucus or phlegm on arising almost every morning?
______times How many times have you had pneumonia?
Yes No Have you had chills or fever with your breathing problem?
Yes No Have you ever had pleurisy?
Yes No Have you ever coughed up blood?

EASONALITY: Mark the following boxes as follows: No Symptoms = 0 Any Symptoms = + Severe Symptoms = ++

AMPLE: If you have hayfever (but no asthma, hives, eczema or arthritis) each Fall only, at home and at work and no symptoms in the winter, your answer might look like this:

ONDITION (Circle your symptoms)	Age Began	Summer	Winter	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Home	Work
thma																	
asal (Congested Nose) (Itchy Eyes) (Sneezing) (Frequent Colds)	11 yrs.	+	0								+	++	+			+	+

ONDITION (Circle your symptoms)	Age Began	Summer	Winter	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Home	Work
thma and/or Chronic Cough heezing, even if slightly)																	
sal (Congested Nose) (Itchy Eyes) (Sneezing) (Frequent Colds)																	
ves																	
ema																	
hritis																	

Parents, grandparents, brothers or sisters who have had any of the following (write in relationship)

Asthma________________ Hayfever________________ Hives________________

Eczema________________ Bee sting allergy________________

ENVIRONMENT:

Type of heat at home hot air_____ hot water_____ electric_____ woodburning stove_____ space heater_____

Type of heat at work hot air_____ hot water_____ electric_____ woodburning stove_____ space heater_____

Animals or pets at home________________ Since when________________ Where do they sleep________________

Animals at work________________ Approximate age of your house__________ City__________ Country__________

Pillows stuffed with (see label)________________ Mattress stuffed with (see label)________________

Type of underpadding of rugs synthetic_______ animal hair_______

House plants (how many)________________

Hobbies and other activities Indoors________________ Outdoors________________

AGENTS:

Circle any of the following that you actually have noticed causing you wheezing, coughing, nose running, nose congestion or hives:

dogs	cats	horses	other animals
barn	beer or wine	gardening	basement
hairspray	wool	rain	insect spray
air conditioning	cosmetics	perfumes	after shave lotion
dust	drafts	humidity	after bath or shower
tobacco smoke	strong odors	alcoholic beverages	fatigue
anything at work	rapid change in temperature	hot weather	cold weather

FOOD AND MEDICATION ALLERGIES:

Food to which you have actually had an allergic reaction________________

Reaction________________ How long after eating it?________________

Medications that have caused a bad reaction (for example rash, swelling, wheezing) Penicillin _reaction________________

Tetanus injection_____ reaction________________ aspirin_____ reaction________________ Name any other drugs to which you are allergic________________ reaction________________

STINGING INSECT ALLERGY:

Stinging insect reaction: (bee, hornet, wasp) local swelling? ________________

Big generalized reaction: (Describe) ________________

PREVIOUS ALLERGY TESTING AND TREATMENT:

Have you been skin tested for allergies?__________ When?_______ by Dr.________________

What reacted? ________________

Have you ever received injection treatment against allergies? __________ Started________________

Date of last injection ________________ What was in the injection?________________

PREVIOUS STEROID TREATMENT:

Have you ever received cortisone medications (Prednisone, Decadron, Medrol, Kenalog, Aristocort, Steroids)by injection or pill?________

Date of last dose __________ How long did you take them?__________ What dose?__________ Every day__________

Every other day________________ Dose was reduced each day________________

Do you or did you ever have diabetes__________ ulcer__________ tuberculosis__________ high blood pressure__________

OTHER MEDICATIONS, INHALER, NOSE SPRAY AND SMOKING:

What medications (pills, capsules, injections, liquids, drops, ointments or sprays) have you taken in the past month? Include aspirins, birth control pills, etc. ________________

Are you or have you ever been a smoker? _____ How many years?__________ Packs per day?__________ Stopped?__________

Do you use a hand spray (mouth) inhaler?________________

When was the last time you used a nose spray or drops?________________

Are you presently taking any of the following medications? (Circle)

Yes	No	Aspirin, Bufferin, Anacin	Yes	No	Laxatives	Yes	No	Shots
Yes	No	Blood pressure pills	Yes	No	Sleeping pills	Yes	No	Water pills
Yes	No	Cough medicine	Yes	No	Thyroid medicine	Yes	No	Antibiotics
Yes	No	Digitalis	Yes	No	Tranquilizers	Yes	No	Barbituates
Yes	No	Hormones	Yes	No	Weight reducing pills	Yes	No	Birth control pills
Yes	No	Insulin or diabetic pills	Yes	No	Blood thinning pills	Yes	No	Phenobarbital
Yes	No	Iron or poor blood medications	Yes	No	Dilantin	Yes	No	Other drugs not listed

ENT SURGERY:

Tonsils removed__________ Age__________ Ear or nose surgery__________ Age__________

FAMILY HISTORY	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers (B) or Sisters (S)				
Husband or Wife				
Sons (S) or Daughters (D)				

PERSONAL HABITS:

Yes No Do you regularly smoke? Cigarettes________ Pipe________ Cigars________

Yes No Do you usually drink over 6 cups of coffee per day?

Yes No Do you regularly drink alcohol? 1 oz. per day______ 2 oz. per day______ 4 oz. per day ______over 6 oz. per day______

Beer: 1 bottle per day ________2 bottles per day ________over 4 bottles per day ________

SURGERY, HOSPITALIZATION AND INJURIES:

Write in the names and year of any operations which you have had:

Operations	Year	Operations	Year

Write in the names of any diseases or conditions you have had which required hospitalization:

Disease	Year	Disease	Year

erious Injuries or Accidents:

	Year

erious Illnesses which you have had: (not requiring hospitalization)

	Year

IMUNIZATIONS:

	Date				
etanus					
lio, oral			*Polio, injection*		
nallpox					
easles					
berculin (PPD or Tine)					
rman Measles					
mps					

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PATIENT Last Name | PATIENT First Name | MI | Date of Birth | Male/Female

Street Address ☐ | PO Box / Apt # ☐ | City ☐ | State ☐ | Zip Code ☐

Home Phone | Cell Phone | Work Phone | Brief Request Call Back | Detailed

Please check which phone number is preferred and note if we may leave a BRIEF or DETAILED message.

E-Mail Address

Insurance 1 | Policy Holder: List NAME if spouse or child, or "Self" | Date of Birth

Insurance 2 | Policy Holder: List NAME if spouse or parent, or "Self" | Date of Birth

Insurance 3 | Policy Holder: List NAME if spouse or parent, or "Self" | Date of Birth

Primary Care Physician | Other Treating Physician / Specialist

School | Address

Employer | Address

For MINORS (under 18): Responsible Party Name | Relationship

Responsible Party Preferred Phone(s) | Date of Birth

Preferred Pharmacy and Location (City, State)

My Mail-Order Pharmacy

_____ I allow BAC physicians to view MY or MY CHILD'S prescription history on file with my insurance plan to check for drug
Initials interactions. *If you do NOT agree, initial here: _____ I DO NOT ALLOW THIS ACTION*

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PLEASE READ AND INITIAL TO ACKNOWLEDGE EACH ITEM

______ **FINANCIAL CONSENT:** This is a "lifetime" financial consent concerning outpatient service records which shall continue in effect unless and until I revoke it by written request. I authorize payment directly to this office, Berkshire Allergy Care, and any benefits payable under the terms of my insurance/third party payer. I understand that I am financially responsible for any charges or remaining balances not covered by my insurance/third party payer. I authorize this office to release all pertinent medical information for purposes of obtaining payment for services rendered, reviewing, or evaluating patient care and preparing continuing care. I will update this office of any changes of insurance or other information that may affect billing in a timely manner.

______ **MISSED APPOINTMENT FEE:** Our office charges a missed appointment fee for all appointments not cancelled with at least 24 hour notice. A charge of $25 will be assessed for follow up appointments. A charge of $50 will be assessed for all new patient and testing appointments.

______ **INSURANCE PLAN DEDUCTIBLES:** Please be aware that if you have a deductible through your insurance, you will be charged a deposit of $150 for new patients and $75 for established patients. This will be charged annually and applied towards your deductible. Any remaining balance will be billed after insurance processing. Thank you in advance for your cooperation.

______ **REFERRALS:** Obtaining a valid referral is a patient responsibility. I may be responsible for payment if my primary care physician has not approved my visit as required by some insurance plans.

______ **RELEASE OF INFORMATION—HIPAA:** I have been offered or have received a copy of this office's HIPAA Privacy Practices policy. Any personal information provided by me is considered confidential and will only be used as defined within the guidelines of that policy.

______ **AUTHORIZATION TO TREAT:** I, for the person acting on my behalf of the, do hereby authorize the rendering of such care, which may include routine diagnostic procedures and such medical treatment deemed necessary by the physician or provider in charge of my care. I acknowledge that no guarantees have been made to me as the result of examination or treatment in this office.

______ I give permission for staff of Berkshire Allergy Care to speak with ________________________, be present at appointments, and share in the care, discuss information and medical treatment for myself/my dependent. Relationship: ______________

The information provided by me is true and accurate to the best of my knowledge. I have reviewed and understand the policies noted.

____

Signature of Patient/Legal Guardian

____

Printed Name

____

Today's Date

BERKSHIRE ALLERGY CARE

Date__________

PATIENT Last Name | PATIENT First Name | M.I. | Date of Birth / / | M / F | Social Security #

Street Address | PO Box / Apt # | City | State | ZIP code

☐ Home Phone | ☐ Cell Phone | ☐ Work Ph | ☐ Brief/request a call back ☐ Brief text ☐ Detailed

Please check which phone # is preferred and note if we may leave a BRIEF or DETAILED message at your preferred phone number.

Policy Number:

Insurance Name | Policy holder name or "self" | Date of Birth (Required!) | Employer Group | Worker's Comp ☐

Insurance Name | Policy holder name or "self" | Date of Birth (Required!) | Employer Group

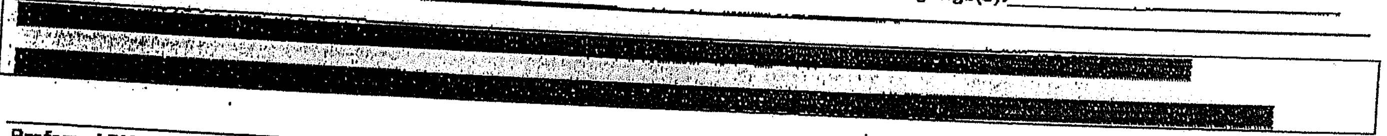
PRIMARY CARE Physician | Other Treating Physician or Specialist | OTHER FAMILY MEMBERS seen here?

For Minors: Mother/Guardian name/lives with child? Date of Birth | Social Security # | Father/Guardian | Date of Birth | Social Security #

Employed? ☐ Name of employer | Student? ☐ Name of school / grade | If over 18 years old, please ask for authorization form!

Responsible Party | Relation to patient? | Date of Birth | Social Security # required if not paying today

PATIENT Status -Circle one: Single Married Divorced Widowed Separated Preferred language(s):__________



Preferred PHARMACY | Street | Town | My MAIL-ORDER PHARMACY

______ Initials I allow BAC physicians to view *my* or *my* child's prescription history on file with my insurance plan to check for drug interactions. * If you do NOT agree initial here→ __________ I do not allow this action.

PLEASE READ AND INITIAL TO ACKNOWLEDGE EACH ITEM *Office Policies and Authorizations*

_________ BENEFITS PAYABLE TO PHYSICIAN: I hereby authorize payment go directly to my physician for medical services provided in this office. I also understand that I am responsible for copayments and any other portion of my bill that is not covered by my insurance company. I will update this office of any changes of insurance or other information that may affect billing in a timely way.

_________ REFERRALS: Obtaining a valid referral is a patient responsibility. You may be responsible for full payment or out of network rates if your primary care physician did not approve your visit as required by some insurance plans.

_________ BILLING FEES: If my copayment is not paid at the time of service, a $5.00 billing fee will be charged to my account. One courtesy statement will be sent for other patient balances. Patient balances over 45 days outstanding will be subject to a $15.00 fee unless arrangements are made in advance with our billing office. I may receive or view a copy of this office's detailed financial policy upon request. Due to bank fee increase, there is a $40 fee for all returned checks or credit card payments. Billing fees are non-covered charges and are not paid by your insurance plan. **Billing problems should be presented to staff as soon as possible so we may assist with resolutions within filing limits.**

_________ RELEASE OF INFORMATION – HIPAA Privacy and Security: I have been offered or have received a copy of this office's HIPAA Privacy Practices policy. I also may view it on the BAC website, www.berkshireallergycare.com at any time. Any personal information provided by me is considered confidential and will only be used as defined within the guidelines of that policy.

For students over 18, parents or caregivers may complete to assign rights to other parties to share in the care of a dependent:
*I give permission for staff of BAC to speak with ______________________________, be present at appointments, and share in the care, discuss information and medical treatment for myself / my dependant. [This statement must be retracted in writing.]
Relationship of person: ______________________________ Restrictions? __________

The information provided by me is true and accurate to the best of my knowledge. I have reviewed and understand the policies noted.

Signature of patient or legal guardian | Print name | Date

Office use only: ID | Verified | Scanned | Update only

Revised 01/18