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, Lametrigine, Lamital, 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
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
20. Tricare
21. Tufts Health Plan **(referrals are needed from the primary care physician for HMO plans)**
22. Unicare
23. United Health Care
24. 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.

PEDIATRIC ALLERGY

Dear Parent:

Please fill out this form and bring it with you at the time of your appointment.

Patients Name:_____DOB:_____AGE:____School Grade:_____

Address: _____

Telephone:_____Mother's Name:_____Occupation:_____

Father's Name_____Occupation:_____Employer:_____

Insurance Company:_____Certificate #:_____

Person to notify in emergency: _____ Telephone: _____

Referring Physcian: _____Address:_____

(A report of this consultation will be sent to your referring physician)

1. **Describe your child's problem:**_____

_____

Previous drugs of benefit: _____

Side Effects: _____

Previous drugs of no benefits: _____

Drugs presently taking: _____

(For patient's over 14 years of age)

History of smoking, alcohol, or substance abuse: _____

2. **Other Symptoms (Please Check)**

____Recurrent ear infections____Frequent Colds____Sinusitis____Headaches____Easily Tired

____Nose Bleeds____Sniffling____Repetitive Sneezing____Mouth Breathing____Itchy Nose

____Runny Nose____Hives____Eczema____Boils____Frequent Soar Throats____Throat Cleaing

____Palate Itch____Night Cough____Wheezing____Itchy Eyes____Puffy Eyes____Red Eyes

____Stomach Ache____Recurrent Fever____Others, Please Specify_____

3. **Circle any of the following that you have noticed triggering or worsening your child's problems:**

Cats Dogs Other Animal Dusting/Cleaning Weather Changes Exercise

Food (Milk, eggs, citrus, etc.) Tobacco Smoke Drugs Grass Cutting Cooking Odors

Emotions Paint Aerosol Sprays Spring Summer Fall Winter

4. **Circle any of the following problems that your child has experienced, age, when it started/stopped.**

Colic_____Spitting up_____Recurrent Diarrhea_____

Hives_____ Eczema_____Runny/Stuffy Nose_____

Asthma_____Chronic Cough:_____Recurrent Fever_____

5. **Family History**

Brothers and Sisters	Age	Eczema, Food Allergies, Asthma, Hives, Hayfever

Father: _____

Mother: _____

Other Relatives: _____

Are there any blood relatives who have or had: (Please Circle)

Emphysema, Tuberculosis, Death in infancy, Bleeding Tendency, or Cystic Fibrosis

6. **Previous hospitalization and/or operations:**

Date:_____Procedure:_____Date of last chest x-ray:_____

Date of last hearing test: (If any)_____

7. **Illnesses(Circle only the diseases your child has had)**

Measles, Mumps, Chickenpox, Whopping cough, Chronic Bronchiolitis,

Pneumonia Hepatitis, Recurrent ear infections

Drug causing Reactions:_____Food causing reactions:_____

Any reaction to stinging insects: _____

8. **Immunizations: (Please give dates)**

DPT:_____Polio:_____Measles:_____Mumps:_____Rubella:_____

*Tuberculin (Time):*_____*Result:*_____*Varicella:*_____*HIB:*_____ *Hepatitis B Vaccine:* _____

Menigiiococcal: _____Influenza:_____Pneumococcal (Pneumonia):_____Others:_____

9. **Birth History/Past History:**

1. Delivery: _____2. Birth Weight: _____3. Complications:_____

4. Breast Feeding: Yes (How long) _____No_____ 5. Formula (Bottle) _____

10. **Behavior/Psychosocial: (Please Circle)**

Timid Aggressive Shy Forward Happy Depressed Dependent Independent Quiet

Bustling Tense Relaxed Friendly Unfriendly Anxious Calm Introvert Extrovert

Maladjusted Well Adjusted

11. **Environment: (Please check or answer the appropriate response)**

a. Where does the child spend most of his time during the day?_____

b. Type of house:_____

c. Age of house:_____

d. How long have you lived in the house:_____

e. Air conditioned:_____

f. What type of heating system do you have:_____

g. Humidifier:_____Air Filter:_____Does Anyone in the home smoke:_____

h. Do you have any pets:_____ Where does the pet sleep/stay:_____

i. Is your basement: Finished_____Damp_____Musty_____

j. Is your child's bedroom: His/her own:_____ Shared:_____

k. Floor Coverings: Wall to wall carpets:_____Area Rugs_____Linoleum_____Wood_____

l. Type of mattress:_____How old:_____Any stuffed Animals in bedroom:_____

m. Type of pillow: Feather_____Foam_____Kapok_____Polyester_____Other_____

n. Windows in child's room: Drapes_____ Curtains_____ Shades_____ Blinds_____

o. Other: Does your child have: Bookcases_____ Wall hanging_____Plants_____

p. Cleaning frequency of room:_____

Berkshire Allergy Care

Thomas B. Edwards, M.D., FACP

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):_____

[redacted]

Preferred PHARMACY | Street | Town | 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 interactions. * If you do NOT agree initial here→ _____ I do not allow this action.

Initials

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 $6.00 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