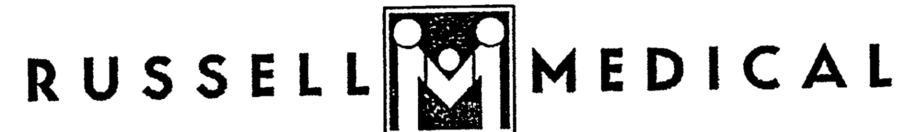


Patient Information

Date of Birth:______________________ Today's Date: _______

First Name: _______________________ MI:_____ Last:_________________________

Sex____ Marital Status: ____________ Email:_________________________________

Address: ______________________________ City:____________________________

State:________________ Zip:_________________________

Phone: (______)_________-___________ Work Phone: (_____)_______-_________

Emergency Contact:

Name: ____________________Relationship:__________ Phone(_____)_____-______

Name: ____________________Relationship:__________ Phone(_____)_____-______

Insurance Information:

Insurance Carrier: ________________________ Insurance Plan: ____________________

Policy/Member number: __________________________ Group: __________________

Social Security #: ___________________ Contact Number: _________________________

Subscriber's Name: _____________________ Date of Birth: ________________________

Health Concerns/ Symptoms

Describe your main concerns (symptoms, onset, diagnoses, duration etc.)

____

____

Russell Medical

Patient Acknowledgement Form For

Patient Name: ____

(Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize Russell Medical to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: Yes_____ No _____ Cell Phone: Yes_____ No_____

Text Message Yes___ NO___

Voice Mail/Answering Machine: Yes_____ No_____ Work Phone: Yes_____ No _____

May we fax medical records for referrals? Yes____ No _____

Please list names of people with whom we can discuss your medical care:

Spouse Name ______________________________________

Parent Name ______________________________________

Other Name(s) & Relationship ______________________________

____

Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier: ______________________________________

(Last four digits of your social security number or mother's maiden name)

I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Signature of Patient or Personal Representative:

______________________________________ Date: __________________

If Personal Representative, give relationship to Patient:

____

[illegible]

Russell Medical Financial Policy

Thank you for choosing Russell Medical as your health care provider. We are committed to providing the best medical care possible to our patients. As part of our professional relationship, it is important that you have an understanding of our financial policies.

1. Insured Patients
   a. As medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance policy is a contract between you and your insurance company and we are not a part of that contract. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered medically necessary under your insurance benefits. All non-covered services will be your responsibility and payment is due at the time you receive your statement. It is your responsibility to know and understand the level of services covered by your insurance company.
   b. As a service to you, we do participate in most insurance plans and we will file your claim for you, if you agree to have the insurance company pay us directly.
   c. Outside laboratories are used for most blood work, biopsies, and cultures. These facilities handle filing of their own charges with your insurance carrier directly. It is your responsibility to notify the staff if your insurance carrier requires a specific outside lab.
   d. We recognize that in some instances, prompt diagnosis and treatment is necessary. In an effort to improve the quality of care you receive, we offer many diagnostic tests and therapeutic services to be performed in-house so that the results are available to you at the time of your visit. These services may not be covered by your insurance. In these instances, payment will be collected at the time of service. We will make every effort to provide our best estimate of cost before the service is provided.
   e. Major Medical Plans (PPO, POS, HMO) and Medicare Part B Plans – If you have a Part D Card please let us make a copy of this card so we file claims on your behalf for vaccines. If you do not have a Part D card and the vaccine is not covered, you will be responsible for the cost of the vaccine.
   f. HMO plans – Before receiving services, you must verify that our physician is listed as your primary care provider with your insurance company. If our physician is not listed as your primary care provider, payment will be due at the time of service.
2. Uninsured Patients
   a. Before receiving services, a $100 deposit is required for patients who do not have an active insurance plan. Best estimates of anticipated charges will be made by our staff prior to your visit, however, you will be responsible for all services rendered, even if they were not part of the initial estimate. Full payment is due when services are rendered unless prior arrangements have been made with a billing representative.
3. General Policies
   a. All co-pays are due at the time of visit.
   b. We will send a statement (to the billing address you provide), notifying you of any balances you may owe. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts are subject to a $10 monthly late fee and may be referred to a professional collection agency. You will be responsible to pay any collection costs incurred, including attorney fees if applicable.
   c. If you are not able to pay the balance in full, you must contact our billing office to discuss a payment schedule.
   d. Failure to keep your account balance current may require us to cancel or reschedule your appointment.
   e. Insufficient Funds – a $30 fee for all returned checks will be charged to your account.
   f. We accept cash, checks, Visa, MasterCard, American Express, and Discover.
   g. There will be a $25 charge for all No Shows.

I have read and understand this financial policy.

_______________________	_______________________	____________
Patient Signature	Patient Name Printed	Date

Allergy Health Assessment

Patient Name: ______________________ DOB: ______________

Were you referred by another doctor: ☐ Yes ☐ No Doctors Name: ______________

Please check all recurrent symptoms:

Nasal Symptoms

- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Sneezing
- ☐ Itchy eyes
- ☐ Watery eyes
- ☐ Itchy nose
- ☐ Itchy ears
- ☐ Itchy throat
- ☐ Decreased taste or smell

Sinus Symptoms

- ☐ Post nasal drainage
- ☐ Frequent throat clearing
- ☐ Sinus pressure
- ☐ Headache
- ☐ Colored nasal mucous
- ☐ Stuffy ears
- ☐ Frequent sinus infections
- ☐ Bad breath
- ☐ Snoring

Chest/Throat Symptoms

- ☐ Wheezing
- ☐ Chest tightness
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing with exercise
- ☐ Difficulty breathing at night
- ☐ Frequent pneumonia
- ☐ Throat tightness
- ☐ Hoarse voice

Skin Symptoms

- ☐ Itching
- ☐ Eczema
- ☐ Hives
- ☐ Swelling
- ☐ Blisters
- ☐ Contact allergy
- ☐ Other
- ☐ __________
- ☐ __________

How long have you had these symptoms?

Nasal __________ Sinus __________ Chest __________ Skin __________

How often do the symptoms occur? (constant, daily, weekly, monthly, off-and-on)

Nasal __________ Sinus __________ Chest __________ Skin __________

Is there any seasonal variation in your symptoms and if so, when are they worse? ☐ Yes ☐ No

Nasal __________ Sinus __________ Chest __________ Skin __________

What medications have you tried for your allergy symptoms? Circle the ones that have helped.

____

____

Your Environment

What environmental triggers have made your symptoms worse?

☐ Mowed grass ☐ Windy weather ☐ Dust ☐ Spending time outdoors ☐ Moldy places ☐ Sweeping or dusting
☐ Cigarette smoke ☐ Pollen ☐ Insect sting ☐ Exercise ☐ Respiratory infections ☐ Weather changes ☐ Laughing
☐ Cold air ☐ Nighttime ☐ Stressful events ☐ Animals (specify) ______________
☐ Perfumes, cosmetics, odors, etc. (specify) ______________

How long have you lived in this area? __________ Where else have you lived? __________

Are you better or worse in this area? ☐ Better ☐ Worse

Do you have any pets? ☐ Yes ☐ No Please list: ______________

Are symptoms worse when around your pet? ☐ Yes ☐ No Any previous pets in the home? ☐ Yes ☐ No

Any smokers in the home? ☐ Yes ☐ No Type of Home: ☐ Appartment/Condo ☐ House

Has your home had water or flood damage? ☐ Yes ☐ No

What kind of work do you do?________________________ Are symptoms worse at work? ❑ Yes ❑ No

Have you travelled out of the country in the past year? ❑ Yes ❑ No Where?____________________

Are there other households you visit frequently? ❑ Yes ❑ No Explain:____________________

Family members with allergies/asthma? ❑ Mother ❑ Father ❑ Siblings

Please list all current medications including inhalers, over the counter medications, vitamins, and supplements:

____

____

____

Any medications that you do not tolerate? ❑ Yes ❑ No If yes, list the medications and the reaction they caused:

____

____

____

Any foods that you do not tolerate? ❑ Yes ❑ No If yes, list the foods and the reaction they caused:

____

____

Medical History (check all that apply)

❑ Cataracts ❑ High blood pressure ❑ Acid reflux ❑ Stroke ❑ Glaucoma ❑ Coronary artery disease ❑ Irritable bowel
❑ Migraine headaches ❑ Hearing loss ❑ Irregular heart beat ❑ Inflammatory bowel disease ❑ Seizure disorder
❑ Frequent nose bleeds ❑ Enlarged heart ❑ Diabetes ❑ Kidney disease ❑ Nasal polyps ❑ Lung disease ❑ Thyroid disorder
❑ Cancer ❑ Eartubes ❑ Sleep apnea ❑ Pituitary disorder ❑ Arthritis ❑ Osteoporosis ❑ Other____________

Previous Allergy Treatment

Other doctors seen for allergies: ❑ ENT ❑ Allergist ❑ Pulmonologist ❑ Dermatologist ❑ Gastroenterologist

Have you had nasal or sinus surgery? ❑ Yes ❑ No When and what were the results?____________

Have you been treated in urgent care or ER with asthma? ❑ Yes ❑ No Last Visit Date?____________

Have you had allergy tests? ❑ Yes ❑ No When and where?____________

Have you had allergy shots? ❑ Yes ❑ No When and where?____________

Social History

Do you now or have you ever smoked? ❑ Yes ❑ No How much & how long?____________

Is there anything else you would like to share regarding your allergies?

____

____

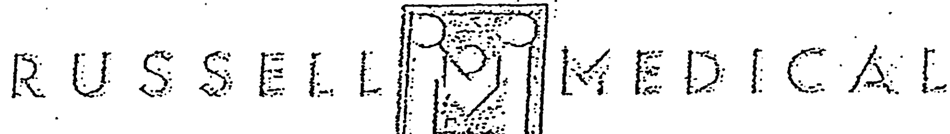
____

If you could fix one thing about your allergies, what would it be?

____

____

____



Authorization to Release Healthcare Information

Patient's Name: ______________________ Date of Birth: ____________

Previous Name: ______________________ Social Security #: ____________

I request and authorize:

Name of Doctor/Office: ____

Address: ____

Phone Number: ________________ Fax Number: ________________

To release healthcare information of the patient named above to:
Russell Medical
4355 Browns Bridge Road, Cumming, GA, 30041
P: 770-771-5050 F: 770-771-5051

This Request and Authorization applies to:

☐ All records

☐ Records relating to the following treatment, condition or dates:

____

Patient Signature: ______________________ Date: ______________

This authorization expires ninety days after it is signed.