

John E. Duplantier, M.D. Mitchell W. Smith, D.O. Rory L. Herron, ANP-BC

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Arrival Time:	
Appointment Time:	
Date:	
Date:	

Thank you for choosing **Central Indiana Allergy**.

In order to provide the most thorough evaluation of your problems, we ask for your assistance with the following items:

- Complete the new patient questionnaire **PRIOR** to your appointment time. Central Indiana Allergy reserves the right to reschedule your appointment if the paperwork has not been completed prior to your appointment time.
- Please arrive on time for your appointment. If you are 15 minutes late, you may be asked to reschedule.
- Request that copies of pertinent medical records and test results (previous skin tests, X rays, CT scans, pulmonary function tests, and lab tests) be faxed to (317) 865-0056.
- Discontinue antihistamine medications prior to your visit (see attached list for details).
- Allow 3 hours for your initial consultation, exam, and testing.
- Please refrain from bringing food or drinks into the office.
- Please refrain from wearing perfume or cologne and from smoking before entering the office as these are triggers for patients with asthma.
- We have implemented revised billing procedures and waiting room guidelines. Please read the attached pages before your first visit.

Insurance documentation must be presented in order to be seen. Please bring you insurance card(s) with you. If your insurance requires a referral, bring the referral form with you or have it faxed to our office. If you have any questions regarding coverage for allergy evaluation or testing, check with your insurance company.

Thank you for your cooperation.

If you have questions, please call our Indianapolis office at (317) 865-0055 or our Mooresville office at (317) 584-3675.

965 Emerson Parkway, Suite B Greenwood, IN 46143 Phone: (317) 865-0055 Fax: (317) 865-0056 902 North Samuel Moore Pkwy Mooresville, IN 46158 Phone: (317) 865-0055 Fax: (317) 865-0056



INSTRUCTIONS FOR NEW PATIENT AND SKIN TEST APPOINTMENTS

Stop using the following antihistamine medications 7 days prior to your appointment:

Allegra (fexofenadine)

Astelin (azelastine) nasal spray

Astepro (azelastine)

Atarax (hydroxyzine)

Clarinex (desloratadine)

Doxepin

Dymista nasal spray

Patanase nasal spray

Periactin (cyproheptadine)

Phenergan (promethazine)

Xvzal

Zyrtec (cetirizine)

Loratadine (Claritin, Alavert)

Stop the following antihistamine medications 3 days prior to your appointment:

Benadryl (diphenhydramine)

Chlortrimeton (chlorpheniramine)

"Cough and cold" combination or "Allergy" preparations that contain diphenhydramine or chlorpheniramine

Allergy eye drops

Alomide (lodoxamide)

Elestat (epinastine)

Optivar (azelastine)

Patanol, Pataday (olopatadine)

Zaditor

Over-the-counter "allergy" eye drops (Visine, Naphcon, etc.)

There is no need to stop the following medications:

Asthma inhalers

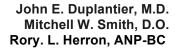
Singulair (Montelukast)

Steroid nasal sprays

(Flonase, fluticasone, Flunisolide, Nasacort, Nasarel, Nasonex, Omnaris, Rhinocort, Veramyst)

Other medications for other medical conditions

If you are taking a beta-blocker medication (for hypertension, heart disease, or migraines), we will not be able to do allergy testing during your initial visit.





Patient No Show Policy

We require a 72 hour notice to cancel your appointment. If you do not provide a 72 hour notice or arrive 15 minutes after your scheduled appointment time, you will be considered a "no-show". Late arrivals of 15 minutes or more will be required to reschedule their appointment.

New Patients

New patients that miss their initial appointment will not be scheduled again unless their primary care physician personally calls Central Indiana Allergy and speaks with either Dr. Duplantier or Dr. Smith. You will be advised that this is our policy if you call to reschedule after missing your initial appointment.

Established Patients

After three missed appointments patients will receive a certified letter and medical record release form dismissing them from the practice. Central Indiana Allergy reserves the right to dismiss the entire family.

Office Guidelines

Out of respect for other patients with food allergies, there is to be **NO FOOD OR DRINK** brought into the waiting room. We will place a receptacle outside the door to dispose of these items before you enter the waiting room. The only exception to this is plain bottled water.

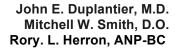
Due to limited seating it is appreciated if only patients and their parents and/or caregiver accompany the patient in our waiting room and exam areas.

If you are bringing a child for an injection, please bring along something to keep them entertained. While we realize that it is hard to contain young children, we need to respect other patients waiting for an appointment. It is also in a child's best interest to remain calm after an injection so as to not aggravate the possibility of a reaction.

Please refrain from wearing strong perfume or cologne and from smoking before entering the office as these are triggers for patients with asthma. No weapons of any type are allowed in our office or on the premises.

Cell phones should be turned off or muted while in the waiting room. You may step outside to take a call but please let the receptionist know if you do so.

Thank you for your consideration in adhering to our office policies and procedures.





Financial Policy

We sincerely wish to provide the best possible care. This involves mutual understanding between the patients and the CIA staff.

You are required to provide proof of insurance coverage (insurance card) at every visit. If your policy has an office visit co-payment, you agree to pay the co-payment at the time of your visit. Patients are responsible to know the terms of their insurance and whether allergy and immunology services are covered. If services are not covered, or your insurance is no longer active, you will be responsible for paying the entire balance.

As a courtesy, we will prepare and file your claim with your specific health plan (s) within timely filing limits. Failure to provide us with the correct insurance information may result in the denial of your claim. We will not file an appeal on your behalf with your insurance company. If further information from you, is requested from your health plan and not received in adequate time, the balance becomes your responsibility. You will receive an itemized statement from our office.

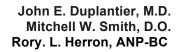
Requirements for maintaining your account in good standing:

- 1. Payment of your co-pay, co-insurance, or up to 50% of balance will be collected prior to your appointment, which is subject to your individual health policy.
- 2. CIA requires balances be paid under \$250.00 prior to mixing immunotherapy vials, and under \$500.00 for Xolair/Nucala patients.
- 3. For services not covered by your health plan, payment at the time of service is necessary.
- 4. All balances over 90 days must be paid in full. If you default on your account and it is assigned to an outside collection agency, you will be immediately dismissed from our practice. All outstanding balances, including collection fees must be paid in full before you may return to our office.

We request that your address be up to date. In the event statements are returned for an invalid address your balance will be subject to collection activity regardless of payment history.

We accept cash, checks, Mastercard, Discover and Visa. We charge \$35.00 for returned checks. Patients who incur NSF/returned check charges will be required to make future payments by cash, credit card or a cashier check.

We appreciate your business and ability to continue to provide the best medical care possible. Please do not hesitate to call our office with any questions.





New Patient Questionnaire

Name:		Date of visit:		
Ref. Physician:		Primary Care I	Physician:	
Reason(s) for visit:_				
Please check the app	propriate space if you	have any of the follo	wing symptoms or con	nditions:
Nose: Stuffiness	s □Discharge d sense of smell □I	☐Itching ☐Sneezin	ng □Postnasal drain	nage Snoring
Sinuses: Headache	es Sinus infections	3		
Eyes: Itching	□Watery discharge	□Redness □Swellin	ng	
Ears:	s □Pressure □Itch	ing		
□Coughing □Frequent	g □Wheezing □S respiratory infections	Shortness of breath ☐ Coughing blood		monia
□Upper	respiratory infections		ptoms'? httime □Morning noke, perfume) □Ao	
Do you have year-ro	ound symptoms?	\Box Yes \Box No		
Please check the app Spring Inside Exercise	□Summer □Fall □Outside □Hor	f the following variab Winter Me Workplace	les make your sympto	ms worse?
Please check the app	propriate box if any of	f the following specif	ic items make your syn	mptoms worse?
☐ House dust ☐ Turning mattress ☐ Basements ☐ Feathers ☐ Cottages/cabins	□Raking Leaves □Mowing grass □Hay or Straw □Barn dust □Dampness	□Birds □Cats □Dogs □Horses □Other Animals	☐ Insect sprays ☐ Scented products ☐ Tobacco smoke ☐ Newsprint ☐ Emotional upset	□ Air pollution □ Temperature Change □ Wind □ Cold/Heat □ Aspirin
Skin: □Hives	□Eczema □Itching	g □Skin allergies (e	e.g., poison ivy, metal)	

-	l food allergy? □Yes List suspected foods:	□No	
	Indicate suspected mar □ Skin □ Gastrointestinal □ Respiratory □ Anaphylaxis	□Hives □Swelling	☐ Itching ☐ Eczema ☐ Diarrhea ☐ Wheezing/asthma
Past Med	ical History		
Medical (Conditions (please list)	Surgeries	(please list)
Please list Date	Hospital	ations or emergency room visit	s. Diagnosis/Treatment
Current N	Medications:		
	Medications: on name and strength	Dose	How many times per day?
Medication	on name and strength	Dose edications that you have tried	
Medication Please list	t allergy and asthma me		d in the past:
Medication Please list	t allergy and asthma me	edications that you have tried	d in the past:
Please list	ever had allergic reaction	edications that you have tried	d in the past:

Social History: Occupation: Workplace exposu If a child grade in sch Day care att Marital status:	ool:eendance?
Maritai Status.	□ Married □ Single □ Divorced □ Widowed
Number	rent or ex-smoker, please indicate: of packs per day? Number of years? nd tobacco smoke exposure?
Review of Systen	18:
General Health:	ε
Eyes:	□Glasses □Contact lenses □Glaucoma □Visual impairment
Head/Neck:	☐ Migraine headaches ☐ Bad breath ☐ Nosebleeds ☐ Broken nose ☐ Ringing in ears ☐ Hearing impairment ☐ Hoarseness
Cardiovascular:	□ Heart murmur □ Palpitations □ Chest pain □ Heart attack □ Blood clots □ Easy bruising □ Swelling of legs
Gastrointestinal:	□ Heartburn □ Difficulty swallowing □ Vomiting □ Ulcers □ Point (annual properties) □
	□ Pain/cramps □ Constipation □ Diarrhea □ Blood in stool □ Hepatitis □ Yellow jaundice □ Pancreatitis □ Gall bladder problems
Genitourinary:	□ Difficulty urinating □ Blood in urine □ Painful urination □ Incontinence
Genitourmary.	□Bladder/kidney infections □Kidney stones □Yeast infections
	☐ Menstrual abnormalities
Skin:	□Acne □Psoriasis □Other
Blood/Lymph:	□Anemia □Blood disorder □Swollen lymph glands
Cancer:	\Box No \Box Yes If yes, list type, site, and current status:
Musculoskeletal:	□ Joint pain □ Back pain □ Osteoporosis □ Rheumatoid arthritis
	□Fibromyalgia □Lupus □Other
Endocrine:	□ Heat/cold intolerance □ Thyroid disease □ Diabetes
Neurologic:	□Stroke □Dizziness □Numbness □Vertigo □Tingling
Psychiatric:	□Extremity weakness □Bell's palsy □Depression □Anxiety □Mood disorder □Schizophrenia
i sycillatric.	□Suicidal thoughts/attempts □Substance abuse
	Other:
Infections:	□ Up to date immunizations □ Yearly flu immunization □ Pneumovax
	Recurrent infections (list locations)
	□Unusual/opportunistic infections □Fungal infections
Entire form reviews	ed in office on with /
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