Western Springs Asthma & Allergy. S.C.
5600 S. Wolf Road, Suite 135
Western Springs, IL 60558

INSTRUCTIONS FOR NEW PATIENTS

******PLEASE READ THIS ENTIRE PAGE******

1. Before your visit, **please print out pages 2-6** below, which include:
   - Registration form (your printer may alert you that margins are too wide; it is okay to print)
   - Office Policies and Financial consent
   - Consent for Release and Use of Confidential Information
   - New Patient Questionnaire (2 pages)

   Please review pages 7&8, which list **medications** that may need to be stopped (see #4, this page).

   A directions sheet (page 9) is provided (if you need it to find our office).

2. Please bring the following to your visit:
   - Insurance card – this is also needed at follow-up visits since contracts or member numbers can change without the patients' knowledge. We use it to verify current coverage and benefits.
   - Referral if you have HMO insurance; we may not be able to see you without it.
   - Picture form of identification, such as a driver's license (for identity theft protection).
   - Forms: please fill them out **before** your arrival as described above.
   - Medication names: please have the names of **ALL** prescription and non-prescription medicines and their doses, both current ones and those recently taken
   - Prior records you feel would help the doctor, including allergy testing, CT/X-rays, etc.

3. Call your insurance company to check your benefits. You *may* have a:
   - Specialist co-pay for office visits, which is due at the time of your appointment.
   - Deductible for the office visit and/or allergy testing. If needed, the two procedure codes for allergy skin testing are 95004 (most often used) and 95024 (less often).

4. Please review the medication list on pages 7&8 to see if any need to be stopped before the visit in case allergy testing will be done.

   - Please do not stop any medications that are not on the list. This includes medications for asthma, blood pressure, diabetes, cholesterol, pain relief, neurological conditions and antibiotics. Please call our office if you are not sure.
   - Continue your antihistamine if you cannot stop due to severe itching or an acute allergic reaction. We can still evaluate and treat you, postponing testing for another time.

We look forward to meeting you and caring for you and your family.

If you have problems with these instructions, please call our office at 708-246-4515.

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REGISTRATION

PATIENT INFORMATION

Legal Name: First _____ Last _____ M _____

Nickname _____ Gender: M F Birthdate _____ Age _____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Marital Status of Patient: Single Married Divorced Separated Widowed

Responsible Financial Party: Self Father Mother Other (specify) _____

Name of Parents or Legal Guardian (if minor) _____

Marital Status of Parents (if minor): Single Married Divorced Separated Widowed

Primary Physician _____ Phone _____

Referred By _____ Phone _____

Preferred local pharmacy name & phone: _____

Mail-order pharmacy company and fax number (if applicable): _____

INSURANCE INFORMATION

PRIMARY ***Co-Pay $*** _____

Insurance Company _____

Legal Name of Insurance Holder: First _____ Last _____ M _____

Insured's birthdate __ __ /__ __ /__ __ __ __

Relationship to Patient: Self Spouse Father Mother Other _____

Insured's Information if different: Phone (H) _____ (C) _____

Address _____ City _____ St _____ Zip _____

ID # or Medicare # _____ Group # _____

SECONDARY

Insurance Company _____

Legal Name of Insurance Holder: First _____ Last _____ M_____

Insured's birthdate __ __ /__ __ /__ __ __ __

Relationship to Patient: Self Spouse Father Mother Other _____

ID # or Medicare # _____ Group # _____

SIGNATURE **DATE**

_____ _____

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OFFICE POLICIES & FINANCIAL CONSENT

******* Please read this carefully and completely*******

- **For PPO's and HMO's**, I give my permission for my insurance company to be billed and for payment to be made directly to my physician.
- **For Medicare patients**, I agree to pay in full at the time of service for charges related to the office visit and any tests or procedures. Medicare will reimburse me for the majority of the office charges. [This is our practice's method of handling Medicare patients as non-participating providers.]
- **HMO Patients**: prior authorization is required prior to each service, and must be presented at the time of service. **Obtaining a valid referral is the responsibility of the patient or guardian**.
- Co-payments are due at the **time of the visit**. If a co-payment is not provided the office reserves the right to reschedule my appointment.
- Until deductibles are met, all services will be paid in full regardless of type of insurance.
- You are responsible for all balances due once your insurance company has responded to the bill. All payments not received by the statement due day will be considered delinquent and appropriate collection action will be taken.
- If not covered by insurance, payment is required on the date services are rendered. [Arrangements to accommodate financial needs can be discussed.]
- Our office accepts cash, checks and VISA/Mastercard.

Please **[X]** the following once you have read them:

[ ] There will be a **$10.00 late fee** assessed **monthly** to accounts that are past due.

[ ] There will be a **$35.00 charge** for no-shows for returning patients. Not showing up affects not only you and the physician, but also someone else who could have had the appointment time. Please note this is not covered by insurance and is your responsibility.

[ ] There will be a **$65.00 charge** for a new patient appointment no-show if cancelled less than 24 hours prior to the appointment. Please note this is not covered by insurance and is your responsibility. This may be waived if the slot can be filled with another patient.

[ ] There may be a **$15.00** charge for personal protective equipment (PPE) as needed for the COVID-19 pandemic; this is billed through insurance, but may be your responsibility based on your deductible.

[ ] **Three (3) No-Show** appointments may result in patient termination from the practice.

[ ] I have read and understand this policy. By signing, I agree to pay any fees that apply as above.

_____
Patient name

_____ _____
Signature of patient or guardian Date

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(708) 246 - 4515

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability Accountability Act (HIPAA) of 1996, I have certain rights to privacy in regards to my personal health information. I understand that the office may modify its Notice of Privacy Practice from time to time, and that I can request a copy at any time or view it on the practice website (on "Our Practice" page). I have a right to request in writing how my personal health information is disclosed; I can revoke this consent in writing, except to the extent actions were taken in the past that relied on this consent.

[ ] Yes, I would like a copy of the Notice of Privacy Practice.
[ ] No, I would not like a copy of the Notice of Privacy Practice.

X _____
Patient name

X _____ **X** _____
Signature of patient or guardian Date

PERSONAL HEALTH INFORMATION RELEASE

I give my consent for the practice to contact me by mail and to leave messages with my medical information at these numbers or with the following people (leave blank if not applicable):

Home phone:	[ ] Yes	[ ] No	Cell phone:	[ ] Yes	[ ] No
Work voicemail:	[ ] Yes	[ ] No	Co-worker:	[ ] Yes	[ ] No
Home fax:	[ ] Yes	[ ] No	Work fax:	[ ] Yes	[ ] No

Additional contacts (other than parents/guardians of a minor):

_____
Name of person we may contact Relationship Phone #1 Phone #2

_____
Name of person we may contact Relationship Phone #1 Phone #2

_____
Name of person we may contact Relationship Phone #1 Phone #2

I agree to the above statements:

Signature: **X** _____ Date: **X** _____

If you are not the patient, please specify your relationship: _____

Name_____DOB_____Date_____

Reason for your visit (briefly describe symptoms/concerns – the doctor will go into more detail):

_____

_____

What medications/treatments you have tried for this problem?

_____

_____

All medical conditions currently being treated by a physician:_____

_____

_____

Any hospitalizations or surgeries? (what/when)_____

_____

Allergy to medications? [ ] No [ ] Yes (list name of med, year, symptoms):

_____

_____

Allergy to food? [ ] No [ ] Yes (list food (s) and symptoms _____

_____

Allergy to insect stings? [ ] No [ ] Yes (what happened):_____ _____

Allergy to latex? [ ] No [ ] Yes _____**Allergy to IV dye?** [ ] No [ ] Yes _____

Allergy to bandages/tape/chemicals? [ ] No [ ] Yes (circle which ones)

Social history

Smokers in home [ ] Yes [ ] No *Use of plug-in fresheners/diffusers/lit scented candles* [ ] Yes [ ] No

O*ccupation/student*: _____*Hobbies*/types of e*xercise*:_____

Pets in home [ ] No [ ] Yes (types):_____ *Pets allowed in bedroom* [ ] Yes [ ] No

Mattress age: ___ *Pillow age*: ___ *Allergy covers* [ ] Y [ ] N *Room HEPA filter* [ ] No [ ] Yes, where _____

Home [ ] Owned [ ] Rented Oldest *wall-to-wall carpet* age: ____ [ ] N/A Which room(s)_____

Basement: [ ] No [ ] Yes -> *Carpeted*? [ ] Yes [ ] No *Home dampness/seepage/mold* [ ] Yes [ ] No

Who lives at home: _____ *For child:* Babysitter/nanny frequency_____

[ ] *Different home* (parent, vacation): How often there_____Pets: [ ] Yes [ ] No Smokers [ ] Yes [ ] No
Other home carpet age: _____ Age of mattress used: _____ Age of pillow used: _____ Allergy covers? Y N

***For patients over 16 yr old**:* Smoker**?** [ ] Never [ ] Quit (when) _____ [ ] Current ____ packs/day for _____ years

Alcohol [ ] No [ ] Yes (how many): _____per week *Cannabis*: [ ] No [ ] Yes *Vaping*: [ ] No [ ] Yes

***Patients under 12 yr old**:* Full term? [ ] Y [ ] N C-section? [ ] Y Breast-fed? [ ] Y Formula problems? [ ] Y [ ]

WESTERN SPRINGS ASTHMA & ALLERGY, S.C. NEW PATIENT QUESTIONNAIRE – PAGE 2

Name_____DOB_____Date_____

Patients under 16 years old: **Immunizations** up-to-date [ ] Yes [ ] No

Patients over 16 years old: Have you ever had pneumonia vaccine (Prevnar/Pneumovax)? [ ] Yes [ ] No [ ] Unsure

If yes, last year given _____

Last year received influenza vaccine_____ or [ ] N/A, why?_____

Family history (Any 1st degree relative: nasal allergy/asthma, eczema, medication/food allergy, autoimmune disease)

_____

_____

Please circle the symptoms that apply to the patient in the *PAST 6 MONTHS*:

General: Poor Appetite Unexplained Weight Loss or Weight Gain Lack of Energy/Fatigue Poor Sleep

Eyes: Itchy Red Burning Tearing Mucus Vision Problems

Ears: Painful Clogged Drainage Frequent Ear Infections Decreased Hearing

Nose: Congestion Sneezing Itching Dripping Loss of Smell or Taste Bleeding

Throat: Pain Hoarseness Itching Throat Clearing Burning Swelling

Sinus: Pain Pressure Drainage Upper Teeth Discomfort

Respiratory: Shortness of Breath Cough Wheezing Chest Tightness Snoring Apnea

Cardiovascular: Murmur Palpitations Fainting Chest Pain with Exertion High Blood Pressure

Gastrointestinal: Nausea/Vomiting Diarrhea Acid reflux (GERD) Abdominal Pain Cramping Gas Constipation Blood in Stools Food Getting Stuck Trouble Swallowing

Hematologic/Immunologic: Easy Bruising Swollen Lymph Nodes Unusual Infections Clotting problems

Skin: Rash Swelling Hives Eczema Rough Patches Itching Burning Pigment Change

Muscular: Joint ache/stiffness Joint swelling/redness Weakness Muscle spasms Development issues (child)

Neurologic: Headaches Dizziness/Vertigo Altered Sensation Migraine Seizures Tics

Urinary: Trouble Urinating Blood in Urine Enlarged Prostate Kidney Stones Bladder Infections

Gynecologic: Menstruating? N/A Y Abnormal Bleeding Y N Planned Pregnancy Soon? Y N N/A

Psychological: Learning issues Anxiety Depression ADD/ADHD Panic Attacks Mood Swings Autism spectrum

Form completed by_____Relation to patient_____

Nurse and doctor use only:

_____

_____

Form reviewed by:_____Date_____

MEDICATIONS NEEDED TO BE STOPPED PRIOR TO THE VISIT (2 PAGES)

The following antihistamine medications will interfere with allergy testing. Please review and stop them as listed. This also applies if any of these are combined with a decongestant, such as Allegra-D or Claritin-D, as well as any OTC medicine ending in "P.M.". Call if you are not sure about your medications' ingredients.

ORAL MEDICATIONS

Continue your oral antihistamine if you cannot stop due to severe itching or allergic reaction. We can still evaluate and treat you, postponing testing for another time.

Stop these oral antihistamines five (5) days before the visit:

- Fexofenadine (**Allegra**, Aller-ease, Aller-fex, Wal-Fex)
- Cetirizine (**Zyrtec**, Aller-tec, Wal-Zyr)
- Levocetirizine (**Xyzal**)
- Loratadine (**Claritin**, Aller-clear, Wal-itin)
- Cyproheptadine (Periactin)
- Desloratadine (Clarinex)
- **Benadryl** (diphenhydramine)
- **Hydroxyzine** (generic Atarax, Vistaril),
- Over-the-counter **allergy and cold preparations**, such as Dimetapp, Tylenol Allergy or Advil Allergy

NASAL ANTIHISTAMINES (stop these nasal sprays two (2) days before visit):

- azelastine (Astelin, Astepro)
- Dymista (azelastine + fluticasone)
- Olopatadine (Patanase)

****NOTE: You do NOT need to stop nasal steroids, such as Flonase, Nasacort, fluticasone, etc.****

Some heartburn (GERD) medications: Please stop these two (2) days before the visit:

- nizatidine (Axid)
- famotidine (Pepcid)

You do **NOT** need to stop PPIs, like omeprazole, Prilosec, lansoprazole, Prevacid, Nexium, Protonix, Dexilant.

*** ***Eye drops*** do **NOT** need to be stopped.***

ASTHMA MEDICATIONS: **If possible,** do not take any of the following inhaled medicines for **at least six (6) hours** prior to your visit. Of course, you should take them if you are having trouble breathing. You should continue any other asthma medications not listed here.

- Albuterol (ProAir, Proventil, Ventolin)
- Combivent
- Duoneb (albuterol + ipratropium)
- Ipratropium
- Levalbuterol (Xopenex)

MEDICATIONS NEEDED TO BE STOPPED PRIOR TO THE VISIT (PAGE 2)

Antidepressants/Anti-anxiety/Other Psychiatric Medications

(Discontinue **48 hours** before testing **only** if cleared with prescribing physician)

Alprazolam/Xanax	Effexor/Effexor XR	Paxil
Amitriptyline/Elavil	Elavil	Protiptyline/Triptil/Vivactil
Amoxaine/Ascedin	Imipramine/Tofranil	Prozac
Buspar	Lexapro	Restoril
Clomipramine/Anafranil	Lorazepam/Ativan	Serzone
Clonazepam/Klonoin	Librax	Trazodone/Desyrel
Celexa	Mapotiline/Ludiomil	Trimipramine/Surmontil
Cymbalta	Mirtazapine/Remeron	Welbutrin (Buproprion)
Desipiramine/Norpramin	Nefazodone/Serzone	Xanax
Doxepin	Nortriptyline/Aventyl/Pamelor	Zoloft

If you are on a medication for anxiety or depression that you do not see on the list, please call us to confirm.

DIRECTIONS TO WESTERN SPRINGS ASTHMA & ALLERGY

There is also a link to our address on Google Maps on our website.

From the east:
Take any major westbound street to La Grange Rd/Mannheim**;** take to 55th Street and turn westbound. Proceed 1.5 miles to Wolf Road and follow directions below for **"From the corner of Wolf Road and 55th Street**".

From the south:
Option A: From Willow Springs Road or La Grange Road heading north: Turn left at 55th Street, proceed to Wolf Road and turn left. Follow directions below for **"From the corner of Wolf Road and 55th Street**".
Option B: Heading north on I-294 North and exiting at Wolf Road or otherwise taking **Wolf Road north from points south**, about ½ mile north of Plainfield Road, look for our entrance on the left, immediately north of Park Place. Park in the rear of the building and enter through the steps to the left of the Western Springs Family Practice.

From the west:
Option A: I-55 North, exiting at County Line Rd North: pass Plainfield Rd. and turn right on 55th Street. Turn right at first light, Wolf Road. Follow directions below for **"From the corner of Wolf Road and 55th Street**".
Option B: I-88 East to I-294 South to Ogden Avenue East: Proceed to Wolf Road and turn right. Travel 2 miles, passing through the town of Western Springs and 47th Street, continuing to 55th Street. Follow directions below for **"From the corner of Wolf Road and 55th Street**".

From the north:
Option A: I-294 South to Ogden Avenue East: Turn right at first light, Wolf Road. Travel 2 miles, passing through the town of Western Springs and 47th Street, continuing to 55th Street.
Option B: From Wolf Rd southbound: Pass through Western Springs, continue to 55th Street.

Follow directions below for **"From the corner of Wolf Road and 55th Street**".

From the corner of Wolf Road and 55th Street (heading south):

- Go one block south to 5600, on the right.
- Before you reach our address, you will pass a small strip mall, an apartment complex and a chain link fence ***immediately*** before the driveway into the medical complex.
- If you reach Park Place, you have just passed the driveway.
- There is a business sign and flagpole in front of the building.
- Park in the rear of the building and enter through the steps in front to the left of Western Springs Family Practice; we are directly above them on the second floor.
- There is a lift for those with difficulty managing the stairs once inside. If you need assistance entering the stairs into the building, please call us in advance for further instructions. There is a wheelchair accessible entrance via the Western Springs Family Practice while they are open.

OUR PHONE NUMBER: 708-246-4515