



WELCOME TO OUR OFFICE

Your appointment is _____ at _____
 in the _____ office. **Please Arrive 15 minutes prior to appointment with completed paperwork.**

If you find it necessary to cancel or change this appointment, please call us 24 hours in advance to avoid a no-show or last minute cancellation fee.

Please complete the enclosed allergy questionnaire and patient information forms and bring them with you for your first appointment. Your complete allergy evaluation will require one or two visits. Your prompt arrival for appointments is appreciated. Patients who arrive late may need to be rescheduled.

Our office hours are:

	<u>College/Antioch</u>	<u>Georgetown</u>	<u>Olathe</u>	<u>Independence</u>
Monday	8:00 to 6:00	8:00 to 6:00.....		
Tuesday	8:00 to 5:00		9:00 to 5:00.....	8:15 to 6:00....
Wednesday	8:00 to 5:00	1:30 to 5:00.....	2:00 to 6:00.....	8:00 to 5:00....
Thursday	8:00 to 6:00	7:30 to 5:00.....		8:15 to 6:00....
Friday	8:00 to 5:00		8:00 to 5:00.....	9:00 to Noon....
Saturday	8:00 to 12:00			

WALK IN CLINIC HOURS: Monday – Friday 8:00am – 11:00am and 1:30pm – 4:00pm

(The Walk-In Clinic is open to all established patients and located at the College and Antioch office.)

Walk-in Clinic is also open at the Independence office Tuesday, Wednesday and Thursday from 8:00 to 11:00)

IMPORTANT NOTICE: TAKE NO ANTIHISTAMINES IN ACCORDANCE WITH “MEDICATION AVOIDANCE LIST” IN YOUR NEW PATIENT PACKET YOU WILL RECEIVE. THIS SHOULD HAVE BEEN DISCUSSED WITH YOU AT THE TIME YOU MADE YOUR APPOINTMENT.

Asthma medications may be taken. Please refer to the enclosed list of medications containing antihistamines. Please call the office at (913) 491-5501 if you have additional questions.

GENERAL INFORMATION: Our doctors are pleased to assist you with your allergy evaluation. Each of our physicians are Board Certified in their primary specialty and have had additional years of medical training in Adult and Pediatric Allergy, qualifying them to evaluate and treat all allergic conditions, asthma and immune deficiency diseases. Dr. Goldstein, Dr. Frankel, Dr. Wald, Dr. Neustrom and Dr. Ward are Board Certified in Allergy and Immunology. Your allergy evaluation will require one or two visits to complete the history, physical examination, skin testing and any necessary laboratory studies. A complete diagnostic summary will be mailed to you and to your primary care physician unless you indicate otherwise. The KCAA physicians conduct research on new drugs and devices. You may be contacted about possible participation in a research study. Participation in research is always voluntary and you may always change your mind about participation. Your participation will not change the basic care you receive at KCAA but it may offer you treatment options that are not available to the general public. Each patient, adult or child, should have his or her own primary care physician for general health management. A parent or legal guardian must accompany minor children. Parent accompanying a child is financially responsible. In the event of a divorce, regardless of divorce decree, the parent accompanying child is responsible for all charges incurred.

TELEPHONE AND EMERGENCIES: We are aware of the difficulties involved in communicating with a medical office. We are asking your help to allow us to better serve you. Our helpful phone nurses will make every attempt to get answers to your questions in a timely fashion. The following information and guidelines should be helpful.

Helpful Hints

- a) Emergent calls are handled in a triage process.
- b) Please hold non-emergency questions to your next appointment if scheduled within a reasonable period of time.
- c) For non-urgent calls, Tuesday – Thursday are best as telephone calls are heavier on Monday and Friday.
- d) We will communicate the results of normal laboratory and X-ray test by phone. Please allow 10 days to receive results before calling.
- e) The exchange, operational when the office is not open is for emergencies only. Please hold prescription refills, questions about test results and minor problems for office hours.
- f) For prescription refill requests call your pharmacy and they will initiate a request to our office for your medications.

Telephone Numbers:

Office.....(913) 491-5501

Billing Department.....(913) 491-1830

Allergy Injection Clinic.....(913) 491- 5477

Telephone System Prompts:

TO - Appointment Clerk..... press - 2
Pharmacist refill line..... press - 3
Allergy Injection clinic..... press - 4
Speak to a nurse..... press - 5
Billing questions/Insurance..... press - 6

BILLING & PAYMENTS: If your insurance is an HMO, it's the patient's responsibility to make sure we have a copy of your referral in our office on the day of your appointment or you will be asked to sign a patient responsibility form and pay of your visit. If we participate with your insurance company, we will file your visit for you as a courtesy. You must provide your current insurance card and be prepared to pay your co-pay amount at the time of service.

If you are scheduled for allergy testing, please call your insurance company to verify how they pay for this service. Make sure you ask them if you have a deductible and if you have met it for this year. Coventry HMO only pays half of the allowable on allergy testing. Your initial allergy evaluation can be a significant expense, so do not hesitate to contact our Business Office at **(913)491-1830** to make payment arrangements. We send monthly statements to all our patients with balances after their insurance has paid. Please notify the Business Office immediately if you or family members have a change in insurance information, primary care physician, or change of address. For your convenience we accept cash, check, Visa and Mastercard.

NO-SHOW/LAST MINUTE CANCELLATION POLICY: Patients who fail to appear for an appointment or failure to cancel an appointment at least 24 hours prior to your visit will result in a \$40.00 fee. This is not covered by your insurance policy.

We look forward to seeing you at your upcoming appointment time. If you have any questions or problems prior to that time, please call the KCAA office at **(913) 491-5501**.

Patient name: _____

Date: _____

Past Medical History of Patient:

Have you ever had any of the following?

<u>Cancer</u>	Yes	No	<u>Skin</u>	Yes	No	<u>Neurological</u>	Yes	No
Lung	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>	Dysplastic moles	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Colon	<input type="checkbox"/>	<input type="checkbox"/>				Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic	<input type="checkbox"/>	<input type="checkbox"/>	<u>Musculoskeletal</u>	Yes	No			
Brain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<u>Psych/Social</u>	Yes	No
Ovarian	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Chronic back pain	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Growth disorder	<input type="checkbox"/>	<input type="checkbox"/>			
						<u>Other</u>		

<u>Heart Disease</u>	Yes	No	<u>Endocrine</u>	Yes	No			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>			
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>			
			Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Ears Nose&Throat</u>	Yes	No	<u>Respiratory</u>	Yes	No			
ENT Problems	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
			Chronic lung disease	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Surgical History

Have you ever had any of the following (Please circle all that apply to the patient)

Cardiac

- Cardiovascular Surgery
- Valvular
- Peripheral vascular Surgery

- Back Surgery
- Shoulder Surgery
- Foot Surgery
- Knee Surgery

GYN Surgery

- C-Section
- Uterine Surgery
- Lumpectomy
- Mastectomy
- Breast Reduction
- Hysterectomy
- Ovary Removal
- Tubal Ligation

EENT

- Ear Tubes
- Cataract Surgery
- Eye Surgery
- Sinus Surgery
- Septoplasty
- Tonsillectomy

GU Surgery

- GU Surgery
- Renal Surgery
- Prostate Surgery
- Vasectomy

Other Surgery

- Neurological
- Thyroid
- Hematologic

Lung

- Lung Surgery

GI Surgery

- GI Surgery
- Ulcer Surgery
- Appendectomy
- Colectomy
- Gall Bladder
- Hernia Surgery
- Hemorrhoidectomy

Musculoskeletal Surgery

- Orthopedic surgery
- Cervical Laminectomy
- Lumbar Laminectomy

Kansas City Allergy & Asthma Associates, PA
AUTHORIZATIONS and FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

Notice: During a visit to our office, patients may receive several different kinds of services, each one may have a separate charge.

_____ **ITEM 1 – Consent to Treat**

Initials I hereby authorize/consent Kansas City Allergy & Asthma Associates, PA (KCAA) and its physicians to treat me/my child.

_____ **ITEM 2 – Assignment of Insurance Benefits**

Initials I hereby authorize and assign, my insurance carrier(s), to make payment directly to KCAA of insurance benefits for services herein specified and otherwise payable to the insured. KCAA files both primary and secondary insurance as a courtesy to patients. I understand and agree that I am financially responsible to KCAA for all charges incurred regardless of potential insurance benefits, including but not limited to Co-Payments, Co-Insurance, Deductibles, Pre-Existing and Non-Covered services. I understand KCAA will not become involved in disputes between the patient and the insurance company. I understand it is my responsibility to verify with my insurance company the physician(s) treating me are covered under my insurance and to get referrals and/or authorization for services.

_____ **ITEM 3 – Requirements at Time of Service**

Initials I understand insurance cards must be presented at time of service or patient will be self pay until cards are presented or if insurance changes within treatment, cards must be presented before KCAA will file claims to new insurance. Co-Payments, Co-Insurance, Deductibles and Non-Covered services are due at time of service. I understand my insurance company may require a referral before being seen – If not obtained I will be responsible for incurred charges until a referral is obtained. I understand that I will receive monthly billing statements. After 60 days, unpaid balances may be transferred to a collection agency with an additional rebilling fee of \$25.00.

_____ **ITEM 4 – Minor Patients (Patients under age 18)**

Initials Any patient under the age of 18 must be accompanied by a parent/guardian to each visit. I understand by signing KCAA's financial policy, I am solely responsible for any incurred charges for the below named patient. Patients under the age of 18 may not cancel or change an appointment in this office.

_____ **ITEM 5 – Returned Check Fee**

Initials I understand if KCAA receives a returned check I will be charged an additional \$25 of the amount on the check and will be on a cash only basis thereafter.

_____ **ITEM 6 – Noncompliance**

Initials I understand KCAA has the right to discharge any patient from this practice at anytime due to non-compliance. If this occurs, records will be released to a physician of my choice only when a signed release of information is received in this office.

_____ **ITEM 7 – Appointments**

Initials I understand KCAA will charge \$40 if I no-show or fail to cancel an appointment without giving 24 hours advanced notice. I understand this charge is not covered by my insurance policy. I understand that if I arrive 15 minutes or more late for an appointment, I may be asked to see an extender or reschedule your appointment.

_____ **ITEM 8 – Housecalls**

Initials I understand KCAA may call the patient's home and/or leave a message to confirm the appointment date, time, location, or any applicable medical instructions. In addition, I understand KCAA may leave a detailed message on my telephone number relating to any lab, x-ray results, and instructions for medical care. I also understand KCAA may send any written communication to my home address.

_____ **ITEM 9 – Notice of Privacy Practices**

Initials I acknowledge that I have read or received a copy of KCAA's Notice of Privacy Practices.

Patient's Signature _____ **Initials** _____ **Date** _____

Guardian or
Other Responsible Party _____ **Initials** _____ **Date** _____

Please List Persons to Whom Protected Health Information May Be Disclosed:

HIPAA Notice of Privacy Practices

Effective as of March/1/2010

[Kansas City Allergy and Asthma Associates, PA](#)
[8675 College Blvd., Suite 200, Overland Park, KS 66210](#)
[913-491-5501](#)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.