AllergyCorp Group

5409 W Friendly Ave, Greensboro, NC 27410
1099 Medical Center Dr., Wilmington, NC 28401

Dear Patient,

Welcome to AllergyCorp Group Clinics. We are pleased you have chosen our clinic for your allergy, sinus, nasal, asthma, smell and taste disorders care.

Please take a moment to read the important information below.

Please arrive 15 minutes before your scheduled appointment time so that we can enter your information in our medical management computer system.

Please note that due to the nature of our practice, you may be at our office for up to 3 hours during your initial evaluation. Please schedule other obligations accordingly.

The itmes below are required during your first visit:

- □ All enclosed forms completed.
- □ Insurance referral if required
- □ Insurance card(s) and any other information that will assist in filing insurance for you.
- □ Photo identification
- □ Medical records of past evaluations and treatments that may relate to your problems.
- □ Any appropriate laboratory and radiological records, x-rays, and MRI/CT scan reports . Additional lab work may be necessary at the time of your visit. Please make sure that you are fully hydrated 24 hrs prior to your appointment, as this will ensure a more successful blood draw.
- □ Names, addresses and phone numbers of other professionals with whom we should be communicating.
- □ ALL medications that you are currently taking, including over-the-counter and herbal.
- □ For a planned procedure(s), your doctor will give you specific instructions for preparing for the procedure. These will depend on your condition, current state of health and any medications you are taking. It may require a second office visit to perform the procedure.
- □ Since your office appointment may take up to 3 hours, bringing some drinks and snacks can be beneficial for your comfort. The cliniuc will be closed for lunch between 1pm through 2pm. There is good number of restaurants (including fast food) near the clinic. If you would need hotel arrangements, our staff can recommend hotels near the clinic.

INSURANCE
Please be sure to identify your insurance plan when scheduling your appointment.
Any pre-authorizations required by your insurance are your responsibility.

We are pleased to participate in many insurance plans. As a courtesy, our insurance department will file your insurance claim for you. In order to provide this service, we will need a copy of your insurance card and a signed authorization form.

APPOINTMENT CONFIRMATION
If you are unable to attend your scheduled appointment, please notify the office at least 48 hours in advance. Failure to do so will result in cancellation fee of $75 for new patient appointments and $35 for established patient.

AllergyCorp Group

PATIENT REGISTRATION

1. PATIENT INFORMATION

Name____________________________________ Birth date__________________ Soc Sec#_________________

Address ______________________________________ City/State______________________ Zip_______________

Home Phone____________________ Work Phone ____________________ Cell Phone ____________________

Marital Status S / M / W / D Student FT / PT Male / Female Occupation ________________________

Other family members at our office? Y / N List names ____

Primary care physician _______________________________ Were you referred to our office? YES / NO

If yes, referred by: ☐ Dr. __________________ ☐ Patient________________ ☐ My insurance company

☐Newspaper Ad ☐ Google/Internet ☐ TV Ad ☐ Radio Ad ☐ Website banner Ad ☐ Billboard ☐ Other

EMAIL ADDRESS ____Would you like to receive email from us? Y / N

2. RESPONSIBLE PARTY

Name_______________________________________ Birth date__________________ Soc Sec#______________

Address ____________________________________ City/State________________________ Zip_______________

Home Phone____________________ Work Phone ____________________ Cell Phone ____________________

3. DF=A5 FM INSUR5 B7 9/POLICY HOLDER INFORMATION

Name_____________________________________ Birth date__________________ Soc Sec#_______________

Address ____________________________________ City/State________________________ Zip_______________

Name of Ins.______________________ ID No. ____________________ Group No. ___________________

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Name_____________________________________ Birth date__________________ Soc Sec#_______________

Address ____________________________________ City/State________________________ Zip_______________

Name of Ins.______________________ ID No. ____________________ Group No. ___________________

5. RECEIPT OF NOTICE PRIVACY PRACTICES WRITTEN ACKNOLEDGEMENT

I, ____, have read a copy of AllergyCorp Group notice of Privacy Practices.

6. AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization be used in place of original. I hereby authorize AllergyCorp Group to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made to AllergyCorp Group.
I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any payments sent to me by my insurance company will be forwarded to AllergyCorp Group to be applied toward my account should a balance exist.

Signature____ **Date**________________________________
(Please type your name - Electronic Signature)

AllergyCorp Group

Financial Policy

The following information is to familiarize you with our billing policies:

- The AllergyCorp Group specialty clinics will bill your in or out of network insurance company for office visits. Any co-pays and/or deductibles will be due at the time of service.. Although eligibility has been checked with your insurance company prior to your office visit, this is NOT a guarantee of payment. **Benefits** are determined by your insurance company once the claim has been received and reviewed.

- If your insurance company was billed and payment is not received within 45 days, the balance will be transferred to the patient's responsibility. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Any portion of the bill not paid, or denied, by the insurance carrier, will be the patient's responsibility.

- If you have Medicare and a supplemental or secondary insurance carrier, please call Medicare and advise them of your secondary or supplemental information for the coordination of benefits. Medicare will coordinate claims with your secondary insurance carrier.

- Upon receipt of payment from your insurance company, you will receive a statement showing your balance due. Payment is expected within fourteen (14) days. For your convenience, we accept Visa, MasterCard, Discover, and American Express.

- If payment, IN FULL, is not received, you may be charged a $15 re-billing fee each time we issue you a statement on an outstanding balance over 30 days.

- If your bill is not paid and is transferred to our professional collection agency, then your information, which may include, but is not limited to, your name, address, phone number, social security number, employment and employment phone number, will be provided to them. You will be charged an additional 25% of your outstanding balance as well as any related court costs and attorney fees.

- If your insurance company requests a claim form, fill out your portion of the form and attach a copy of your itemized statement provided by our office. A physician's signature ***is not*** required. It is not necessary for our office to fill out the "Attending Physicians" portion of the claim. The statement is authentication in itself.

- You must inform our office if you have a new insurance carrier or if the insurance carrier has a new claim address. Please send us a copy of the front and back of your new insurance card so we can update our records. Failure to do so may result in

delayed claims and/or responsibility for unpaid claims.

- If you are unable to attend your scheduled appointment, please notify the office at least 48 hours in advance. Failure to do so will result in a cancellation fee of $75 for new patient appointments and $45 for established patient appointments.

- Please note: This office reserves the right to change its fees at any time without prior notice.

____

Patient Name (please print)

____ ____________________

Patient Signature (Please type your name-Electronic Signature) Date

AllergyCorp Group

Office Policies

We look forward to your visit to the AllergyuCorp Group specialty clinics. In order that our staff and physicians can provide you with prompt service, we ask that you do the following:

Please bring your medical insurance card(s) with you. We must make a copy of the card(s) for our records. Many medical insurance plans place limitations on which physicians or medical facilities their enrollees may use and still be covered. We encourage you to contact your primary care physician or your insurance company to familiarize yourself with the benefits of your medical insurance plan. Failure to obtain a referral could result in non-coverage by your insurance company; therefore, you could be held responsible for any charges resulting from this visit. If you belong to a managed care program, you must get referral(s) from your primary care physician.

The initial visit includes a history and physical examination. Battery of tests is usually required and usually include allergy testing (prick, intradermal, blood), pulmonary functional testing, airway inflamation and other laboratory testing.Depending on the outcome, you may be advised that further evaluations is indicated, such as nasal endoscopy, radiological examination (CT and/or MRI) of the head and sinuses. If any of theses tests have been done within the 6-months, or you have undergone a CT or MRI of the head or neck, please bring the reports with you, as the tests may not have to be repeated. Other tests may be required, and would be at an additional charge.

The costs of the initial visit vary from patient to patient, depending upon the specific problem and the procedures or tests involved. For more information regarding the cost of services, contact our office and ask for the patient coordinator.

Full payment is expected before the time of service, unless you have Medicare or a commercial insurance that is contracted and in network with our practice. As a courtesy to all patients, we will assist you in billing your insurance for your office visits, provided you submit a current copy of your insurance card. We ask that you pre-pay up to the outstanding deductible and any applicable copay and/or coinsurance. Any services not covered or denied by your insurance company will be your responsibility. If you are a member of an HMO, EPO, or POS in which the AllergyCorp Group specialty clinics participates, you must also bring a copy of your primary care physician referral.
If you are not sure of the type of plan that you have, please contact the customer service of your insurance plan to determine whether you will need a referral to the Smell and Taste Clinic in order to receive benefits.

If you are unable to attend your scheduled appointment, please notify the office at least 48 hours in advance. Failure to do so will result in cancellation fee of $75 for new patient appointments and $35 for established patient appointments.

Advance Beneficiary Notice
Diagnostic Procedures

It is the goal of the Physicians at the AllergyCorp Group specialty clinics to offer you the best treatment plan based on the most accurate diagnosis. To obtain this diagnosis, our doctors may or recommend procedures tests to be performed during your visit.

These procedures may include, but are not limited to:

- Nasal Endoscopy / Laryngoscopy – an in- office surgical procedures using a sterile small camera to examine the nasal cavity and the larynx (throat).
- Allergy Testing – prick and intradermal skin testing, patch skin testing and blood (in viro) testing
- Respiratory Tests - that include pulmonary functioning testing, airway inflamation and other laboratory testing.

Depending on your insurance company's rules and regulations, you may be financially responsible for some or all of the cost of these procedures.

☐ I understand that my co-pay is for a routine office visit. Additional diagnostic procedures and tests are not included in a routine office visit and will result in additional charges. I will assume financial responsibility for charges that may be billed to me as a result of any diagnostic procedures / tests performed. Depending on my specific benefit plan the procedure / test charges may be applied to an annual deductible or co-insurance.

OR

☐ I do not authorize any procedures / tests to be performed during this visit, and by doing so, I understand that this may limit the information the doctor has available to determine the diagnosis and subsequent treatment.

______________________________ ______________________
Printed Name of Patient Date

____
Patient's / Legal Guardian's Signature (Please type your name - Electronic Signature)

AllergyCorp Group

Cenpqy ngfi go gpv''qh'Tgegkr v'qh'P qvkeg'qh'Rtkxce{''Rtcevkegu''

Patients Name: --

Date of Birth: --

Chart#: --

I understand and have been provided with a copy of the Notice of Privacy Practices for AllergyCorp Group specialty clinics.

____________________________________ ______________________________

Patient/Legal Guardian/POA (please attach documents) Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- o An emergency existed & a signature was not possible at the time.
- o The individual refused to sign.
- o A copy was mailed with a request for a signature by return mail. o

  Unable to communicate with the patient for the following reason: ____
- o Other: ____

Prepared By: ---------------------------------------

Signature: ___________________________ Date: __________

Relationship to Patient: ______________________________________

Revised January 1, 2016 Staff Initials: _________________

PATIENT HEALTH & ALLERGY HISTORY FORM

Patient Name: ______________________ ID#: ____________

Date: ______________ Patient Age: ________ Sex: ☐ M ☐ F

Occupation: ______________________________

Race: ☐ White ☐ Hispanic ☐ Black/African-American ☐ Asian ☐ Native American ☐ Other ____________

EXISTING CONDITIONS:

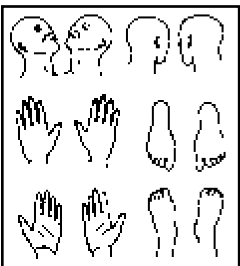
☐ Cancer ____________
☐ Cardiovascular Disease ____________
☐ High Blood Pressure ____________
☐ Alcohol/Drug Abuse ____________
☐ High Cholesterol ____________
☐ Lung/Respiratory Disease ____________
☐ Infectious Disease ____________
☐ Pregnancy ____________
☐ Immune Disorders ____________
☐ Obesity ____________
☐ Stroke ____________
☐ Diabetes ____________
☐ Depression ____________
☐ Liver Disease ____________
☐ Kidney Disease ____________
☐ Neurological Disorders ____________
☐ Allergies ____________
☐ Menopause ____________
☐ Puberty ____________
☐ Skin Disorders ____________
☐ Other ____________

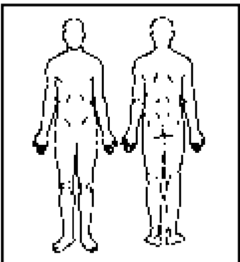
CURRENT MEDICINES:
OTC & Rx
(dates, dosages)

☐ Vitamins/Minerals ____________
☐ NSAIDs ____________
☐ Asthma Medications ____________
☐ Oral Contraceptives ____________
☐ Sedatives/Sleep Aids ____________
☐ Rx Pain Meds ____________
☐ Oral Hypoglycemics ____________
☐ Hormones ____________
☐ Diuretics ____________
☐ Statins ____________
☐ Herbs ____________
☐ Aspirin ____________
☐ Antihistamines ____________
☐ Thyroxin ____________
☐ Steroids (nasal/topical) ____________
☐ Antidepressants ____________
☐ Insulin ____________
☐ Antibiotics/Antifungals ____________
☐ Other BP Medications ____________
☐ Anticoagulants ____________
☐ Other ____________

MEDICAL DEVICES:
including dental

☐ Implants ____________
☐ Braces ____________
☐ Crowns/Bridges ____________
☐ Stents ____________
☐ Fillings ____________
☐ Other ____________





Current Complaint: ______________________________

Date of onset and/or duration: ______________________________

At onset: Area(s) affected: ______________________________

Severity: ☐ Mild ☐ Moderate ☐ Severe

Type and pattern of eruption: ______________________________

Now: Area(s) affected: ______________________________

Severity: ☐ Mild ☐ Moderate ☐ Severe

Currently: ☐ Stable ☐ Increasing ☐ Decreasing ☐ Unclear

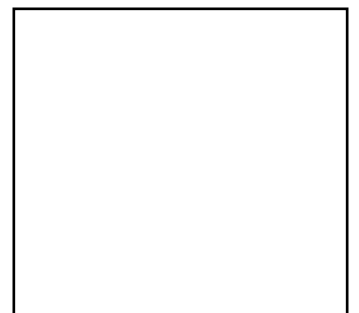
Worsens: ☐ During work week ☐ After weekend

Improves: ☐ After weekend ☐ After holidays/vacations

Outbreaks Occur: ☐ Stable ☐ Increasing ☐ Decreasing ☐ Unclear

Previous Outbreaks: ☐ No ☐ Yes

Date(s): ______________________________



HISTORY OF ALLERGIC DISORDERS:

☐ Asthma ☐ Hay Fever ☐ Childhood Eczema ☐ Urticaria

Food Allergies: ☐ Known ☐ Suspected ☐ Type: ______

Other Known Allergies: ☐ Nickel/Metals ☐ Flowers/Trees/Glasses ☐ Perfume/Fragrance ☐ Latex (type I) ☐ Insects ☐ Medicines ☐ Rubber ☐ Animals ☐ Other: ______

Suspected Allergies: ______

Previous Drug Reactions: ☐ None ☐ Yes (drug/date) ______

Family History of Allergies & Asthma: ☐ Yes ☐ No **Hay Fever:** ☐ Yes ☐ No

Relationship (name): ______ Disease (name): ______

Relationship (name): ______ Disease (name): ______

HOME ENVIRONMENT:

☐ Home ☐ Apartment/Condo **Constructed after 1980?** ☐ Yes ☐ No **Renovated since 1980?** ☐ Yes ☐ No

Location: ☐ Suburban ☐ Urban ☐ Rural ☐ Other: ______ **Lived there since:** ______

Pets: ☐ None ☐ Cats ☐ Dogs ☐ Birds ☐ Rodents ☐ Livestock: ______ ☐ Other: ______

Current animal contact: ☐ Daily ☐ Rare ☐ Occasional **Pets in house?** ☐ Yes ☐ No

Pets/animals as a child? ☐ None ☐ Yes Type? ______ **Contact?** ☐ Rare ☐ Frequent

Symptoms around animals: ☐ No ☐ Yes Describe: ______

Housecleaning frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Participate in housecleaning: ☐ Never ☐ Always ☐ Occasionally ☐ Rarely

Equipment/materials used: ______

Help with laundry? ☐ Never ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Symptoms at home? ☐ No ☐ Yes Describe: ______

SPORTS/HOBBIES:

☐ Golf ☐ Tennis/Racquetball ☐ Woodworking ☐ Computers ☐ Baseball ☐ Sewing ☐ Football

☐ Skiing ☐ Knitting/Needlework ☐ Paper Crafts ☐ Ceramics ☐ Piano ☐ Painting

☐ Guitar ☐ Running/Hiking ☐ Home Repairs ☐ Basketball ☐ Photography

☐ Other: ______

Frequency: ☐ Daily ☐ Few times weekly ☐ Weekends only ☐ Rarely ☐ Duration: ______

Equipment/materials used: ______

______

Symptoms with sports/hobbies: ☐ No ☐ Yes Describe: ______

PERSONAL CARE:

☐ Handwashing frequency: ______ Soap type: ______

☐ Bathing frequency: ______ Soap type: ______

☐ Deodorant use/ frequency: ______ Deodorant type: ______

☐ Lotion use/ frequency: ______ ☐ Creme use/ frequency: ______

☐ Cologne/perfume use/ frequency: ______ ☐ Aftershave use/ frequency: ______

☐ Shaving cream use/ frequency: ______ ☐ Hair color use/ frequency: ______

☐ Toothpaste use/ frequency: ______ ☐ Mouthwash use/ frequency: ______

☐ Shampoo use/ frequency: ______ ☐ Conditioner use/ frequency: ______

☐ Nail polish use/ frequency: ______ ☐ Artificial nail use/ frequency: ______

☐ Contact lenses use/ frequency: ______ ☐ Saline cleaner use/ frequency: ______

Makeup Use: ☐ Foundation/Base ☐ Blush ☐ Eyeshadow ☐ Eyeliner ☐ Mascara ☐ Remover ☐ Lipstick/Gloss/Liner ☐ Concealer ☐ Face Powder ☐ Other: ______

Facials: ☐ Toner/Astringent ☐ Masque ☐ Moisturizer/Cream ☐ Cleanser ☐ Other: ______

Condoms/diaphragms: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Don't use ☐ Type: ______

Other personal care products use/frequency: ______

Symptoms with personal care: ______

JEWELRY & TATTOOS:

Wear: ☐ Daily ☐ Few Times each week ☐ Weekends ☐ Rarely ☐ Never

Jewelry type: ☐ Earring(s) ☐ Ring(s) ☐ Bracelet(s) ☐ Watch(es) ☐ Necklace(s)

Piercing(s): ______________________________

Tattoos: ☐ Recent ☐ Old ☐ Permanent ☐ Temporary ☐ Henna-based

Symptoms with jewelry/tattoos: ______________________________

EMPLOYMENT HISTORY:

Current employer: ______________________________ **Since (date):** ______________

Job title: ______________________________ **Since (date):** ______________

Job description: ______________________________

Employer at onset of dermatitis: ______________________________

Previous job description and duration: ______________________________

Previous/current contact: ☐ Metals ☐ Dust ☐ Vibration ☐ Cold/Heat ☐ Fibers ☐ Chemicals ☐ Fumes ☐ Other: ______________________________

Work environment: ☐ Office ☐ Factory ☐ Hospital ☐ Construction Site ☐ Farm ☐ Laboratory ☐ Indoors ☐ Outdoors ☐ Other: ______________________________

Work equipment: ☐ Gloves ☐ Boots ☐ Apron ☐ Mask/Respirator ☐ Face Shield ☐ Head Cover ☐ Badge ☐ Monitors ☐ Overalls ☐ Other: ______________________________

Symptoms at work: ______________________________ **Since (date):** ______________

Description of work when rash began: ______________________________

Materials used at work: ______________________________

☐ **Treat and/or** ☐ **document at place of employment:** ______________________________

Effect of weekends/holidays/vacations: ☐ Same ☐ Improves ☐ Worsens

Loss of work: ☐ No ☐ Yes, on dates: ______________ **Other workers with same problem?** ☐ No ☐ Yes

Previous compensation claims: ☐ No ☐ Yes, for: ______________________________

☐ **Part-time or** ☐ **second job:** ☐ No ☐ Yes, as: ______________________________

2nd job description: ______________________________

2nd work environment: ☐ Office ☐ Factory ☐ Hospital ☐ Construction Site ☐ Farm ☐ Laboratory ☐ Indoors ☐ Outdoors ☐ Other: ______________________________

Symptoms at 2nd job: ☐ Same as above ☐ Different: ______________ Since (date): __________

NOTES: ______________________________

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URTICARIA (HIVES) QUESTIONNAIRE

☐ No Urticaria (Hives) Problem

Date this episode of hives first started: ____________________
How did it start? ____________________________________
Did you have hives prior to this episode? _________________
If so when?________________
How long did it last?_______________
How was it treated?__________________________________
How often do you break out?
- ☐ Daily
- ☐ 3-5 times a week
- ☐ Weekly

How long does each individual hive last?
- ☐ Few hours
- ☐ A day
- ☐ Few days

Hives are:
- ☐ Itchy
- ☐ Painful

Hives are brought on by the following physical stimulation:
- ☐ Cold
- ☐ Exercise
- ☐ Heat
- ☐ Pressure (tight clothing)
- ☐ Scratching skin

Hives are brought on by the following foods:
- ☐ Dried fruits
- ☐ Beer, wine
- ☐ Avocado
- ☐ Banana
- ☐ Any pitted fruit (peach, plum, cherry, nectarine)
- ☐ Other: List__________________________

Hives are brought on by the following medications:
- ☐ Aspirin
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Penicillin (Amoxicillin, Augmentin)
- ☐ Other: List__________________________

Associated conditions with hives (skin):
- ☐ Swelling of eyes, lips or other parts of body
- ☐ Joint pain
- ☐ Joint swelling (not just hives over the joints)

Associated conditions with hives (respiratory)
- ☐ Sneezing, itchy, runny nose
- ☐ Hoarseness
- ☐ Coughing
- ☐ Wheezing

Associated conditions with hives (gastrointestinal)

- ❑ Itchy mouth
- ❑ Swollen tongue
- ❑ Difficulty swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal pain
- ❑ Diarrhea

List any infections in the 2 months prior to the onset of hives:______________________

____

List any medications taken in the past month: __________________________________

____

____

Family members with hives lasting for more than 2 months:

- ❑ Yes
- ❑ No

AllergyCorp Group
Dimitri Z Pitovski, MD

Health History / Photo Release

I, ____, (Participant) irrevocably grant to AllergyCorp Group / Dimitri Z Pitovski, MD its subsidiaries, affiliates, nominees, licensees, their successors and assigns, and those acting with its authority, with respect to the photographs, film or tape, video, x-rays, digital images, etc. taken on behalf of the Licensor (the "Images", the unrestricted, absolute, perpetual, worldwide right to:

a) reproduce, copy, modify, edit, create derivatives in whole or in part, or otherwise use the Images or any part thereof in combination with or as a composite of other matter, including, but not limited to, text, de-identified health history information, data, images, photographs, illustrations, media or embodiment, now known or hereafter to become known, including, but not limited to, all formats of computer readable electronic magnetic, digital laser or optical-based media (the "Works") for the following purposes:

   i. research, educational and promotional purposes

   ii. inclusion in journals and magazines

   iii. inclusion in corporate promotions, postcards, brochures,

   iv. catalogs, web pages, newsletters, and

b) display, perform, exhibit, distribute, license, sell, transmit or broadcast the Works by any means now known or hereafter to become known.

I hereby waive all rights and release and discharge the Licensor from, and shall neither sue nor bring any such parties for, any claim, demands or cause of action whether now known or unknown, for defamation, invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of the Images.

I agree that there shall be no obligation to utilize the authorization granted by me hereunder. The terms of this authorization shall commence on the date hereof and be without limitation. I warrant and represent that I am "over" the age of 18 years and that I am free to enter into this agreement.

Printed Name:____________________________________ Date: ___________
Signature:_____________________________________

Signature of Parent / Guardian:______________________________________