



Allergy & Asthma Specialty Clinic

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Welcome to the Allergy & Asthma Specialty Clinic. We specialize in the care of adults and children with allergies, asthma, eczema, hives, anaphylaxis and immunodeficiency.

During your initial visit, a detailed history and physical examination, pulmonary function test (if you have asthma) and allergy skin tests will be performed. For most allergy-related illnesses, every effort will be made to accomplish these tests in one visit.

Please review the following information carefully.

Appointment Scheduled For: _____

Appointment Date/Time: _____

Clinic Site: Willmar Office (1037 19th Ave SW)

Hutchinson Health Clinic (3 Century Ave SE)

Marshall Avera Hospital Outreach Area (300 S. Bruce St.)

IMPORTANT: YOU MUST STOP TAKING ALL ANTIHISTAMINE (anti-allergy) MEDICATIONS FOR 7 DAYS PRIOR TO YOUR APPOINTMENT. Taking an

antihistamine would interfere with allergy skin testing. If you have any questions about your medication, please call our office and we will be happy to assist you. Some examples of common antihistamines are listed on page 2.

****CHECKLIST** - BRING THE FOLLOWING TO YOUR APPOINTMENT:**

- Patient History Questionnaire** (enclosed). Complete the LEFT SIDE of the form only.
- Patient Registration Form** (enclosed). Complete - do not leave any questions blank.
- Patient Insurance Card(s)** including prescription plan card. Please verify coverage if you are in a special network or need pre-authorization prior to your appointment. It is your responsibility to obtain referrals, if needed.
- Patient Medical Records.** A copy of your previous allergy/asthma related medical records, especially any allergy testing or lung function testing performed, is needed for review. Contact your previous clinic to obtain these or you can find a records release form on our website www.willmarallergy.com to submit by mail or fax.
- Medications.** All prescription and over-the-counter medications you are currently taking must be listed in the Patient History Questionnaire. Please bring them with you to your appointment.
- Method of Payment.** Copays are due at time of services. A payment of \$200 may be requested if you have an unmet deductible.

IMPORTANT: YOU MUST STOP TAKING ALL ANTIHISTAMINE (anti-allergy) MEDICATIONS FOR 7 DAYS PRIOR TO YOUR APPOINTMENT. This includes combination antihistamine/decongestants and over-the-counter allergy medications. Please be aware that antihistamines can usually be found in antidepressants, sleep aids and almost always in cough & cold medicines. Some common antihistamines include Allegra (fexofenadine), Atarax (hydroxyzine), Benadryl (diphenhydramine), Claritin (loratadine), Dimetapp, Tylenol PM, Xyzal (levocetirizine) and Zyrtec (cetirizine).

You may continue taking nasal sprays (except Astelin, Patanase, and Dymista). If you are taking medications for anxiety, depression or trouble sleeping, please contact our office prior to stopping them.

If you are taking asthma medications such as Advair, Symbicort, Dulera, Pulmicort, Asmanex, QVAR, Flovent, Ventolin, Xopenex, Proventil, albuterol, Maxair, Azmacort, Vanceril, Aerobid, Serevent, Accolate, Singulair or theophylline; it is important you continue taking them.

Please bring all of your current medications with to your appointment. Call if you have questions.

YOUR APPOINTMENT: Patients under 18 years of age must be accompanied by a parent or guardian. Initial appointments may take 1-2 hours so schedule appropriately and arrive 15 minutes early. As a courtesy to other patients and our office staff, please notify us at least 24 hours in advance if you must cancel or reschedule your appointment. If you fail to appear at your scheduled appointment without notification, we will not be able to schedule a future appointment. If you have questions or concerns, feel free to contact us toll free at 1-877-866-4824 or visit our website at www.willmarallergy.com.

FINANCIAL POLICY: Please understand that payment of your bill is considered a part of your treatment. We **urge** you to call us **prior** to your appointment to discuss the approximate cost of treatment. Please be prepared to pay the cost of your visit at the time of service (we accept checks, cash, and Visa and MasterCard). If you have current insurance please bring all insurance cards with you. We will file claims electronically to your insurance carrier; if any claim is disputed by the insurance company, the payment for that claim immediately becomes due. See our complete financial policy at the clinic.

REFERRALS: If you are questioning whether your insurance requires a referral, please call the number on the back of your card. Most BlueCross BlueShield policies do not require a referral, except the policy with the state of Minnesota shown on the upper right corner (example shown below).



BlueCross BlueShield
of Minnesota



LOCATION: Our Willmar clinic is located on the south side of 19th Ave SW between Rice Home Medical and Evangelical Free Church. Turn south onto 11th Street and make a quick left into our parking lot. Please call if you need help with directions.

We thank you for allowing us to assist you. Please call us if you have any questions about your visit to our office. See you soon!

PATIENT REGISTRATION FORM

Please complete all the information below in print, please do not leave any questions blank. Thank You!

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Ph: _____ Work Ph: _____ Mobile Ph: _____ Age: _____ Sex: _____
Race: _____ Marital Status: _____ PIN: _____ Language: _____
Email Address: _____

PRIMARY INSURANCE INFORMATION:

Name: _____ Policy No: _____ Group No: _____ Phone: _____
Copay: _____ Co Ins: _____ Address: _____
City: _____ State: _____ Zip: _____ Guarantor: _____
Relationship: _____ Employer: _____ ID: _____ DOB: _____

SECONDARY INSURANCE INFORMATION:

Name: _____ Policy No: _____ Group No: _____ Phone: _____
Copay: _____ Co Ins: _____ Address: _____
City: _____ State: _____ Zip: _____ Guarantor: _____
Relationship: _____ Employer: _____ ID: _____ DOB: _____

EMPLOYER INFORMATION:

Name: _____ Phone: _____ Status: _____
Address: _____ Occupation: _____
City: _____ State: _____ Zip: _____

REFERRING PHYSICIAN INFORMATION:

Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____

PRIMARY PHYSICIAN INFORMATION:

Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____

MOTHER INFORMATION:

Name: _____
Address: _____
City/ST/Zip: _____
Home Ph: _____ Work Ph: _____

FATHER INFORMATION:

Name: _____
Address: _____
City/ST/Zip: _____
Home Ph: _____ Work Ph: _____

PHARMACY:

Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

REASON FOR VISIT:

Injury: Yes _____ No _____ If Yes, Was It Work Related: _____ Auto Accident: _____
Was it reported to your employer or auto insurance? Yes _____ No _____ Date of Injury: _____

AUTHORIZATION TO PAY:

I hereby authorize payment directly to the business office of this physician/clinic for surgical or medical benefits, if any, otherwise payable to me for service. I understand that I am financially responsible for the charges not covered by my insurance.

Sign (Patient or Guardian) _____

Date: _____

