ALLERGY ASSOCIATES, P.C.

Adult & Pediatric Allergy / Asthma / Clinical Immunology
812-378-3131
800-295-0545

Robert W. Petry, M.D.

815 Schnier Street
Columbus, IN 47201

225 S. Pine Street, Suite 230
Seymour, IN 47274

Namrata Singhal, M.D.

1101 W. Jefferson, Suite U
Franklin, IN 46131

Dear Patient:

Thank you for choosing Allergy Associates for your continued medical care.

We have enclosed patient information for you to complete and bring with you. **Do not take antihistamines for seven days prior to your appointment** (if you can tolerate it) as this will interfere with testing. This includes over-the-counter as well as prescription and cough medications that contain antihistamines. Please note that some antidepressants have antihistamine action. **DO NOT stop all medications (including asthma medications), just the antihistamines.** If you have questions regarding medications, please call our office.

Please allow 2-4 hours for the initial visit. If this is not possible, call our office and we can make arrangements for a consultation and do testing at another time. If you are unable to keep your appointment, please kindly call the office 24 to 48 hours in advance.

If you have questions, comments, or problems obtaining an appointment you may call Rosie, the Office Manager, or Judy, the Clinical Manager.

We would also like to take this opportunity to explain our policy regarding your insurance. We file to all insurance companies but are only contracted with the following:

Some Aetna plans, Anthem Blue Cross/Blue Shield, Choice Care Network PPO, some Cigna plans, Cofinity, Coventry Health, Encore, First Health Network, Great-West Healthcare, Healthspan, Healthy Indiana Plan through Anthem, Healthy Indiana Plan ESP, some Humana plans, Indiana Health Network, Key Benefit, most Indiana Medicaid programs, Medicare, Multiplan, One Health Plan, PHCS, PPOM, Sagamore Heath Network, SIHO, Suburban Health Organization, Tricare, Unicare, and United Healthcare, and many others.

Please bring your most recent insurance card with you prior to your appointment. Also, please contact your insurance company prior to your visit to make sure allergy services are covered under your plan. If your insurance company requires a referral, it is your responsibility to make sure it has been completed. Referrals may be needed for office visits, testing, labs, X-rays, CTs, etc.

We ask that co-pays and deductibles be paid at the time of service unless other arrangements are made. We look forward to meeting you.

Sincerely,

Allergy Associates, P.C.
Dr. Petry, Dr. Singhal and Staff

ALLERGY ASSOCIATES, P.C.
815 Schnier Street, Columbus, IN 47201
Telephone (812) 378-3131

PATIENT REGISTRATION (please print and complete in full)

Last name _____ First name _____ M _____

Address _____City _____ State _____ ZIP _____

Home phone _____ Cell phone _____ Sex: ❑ M ❑ F

Email address _____

Marital status: ❑S ❑M ❑D ❑W Date of birth _____ Social Security # _____

Race ❑American Indian/Alaska Native ❑Asian ❑Black/African American ❑Native Hawaiian/ Pacific Islander ❑White ❑Declined

Ethnicity ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Declined ***Preferred language*** _____

Preferred pharmacy and location __ _____

Employer _____ Work phone _____

Who is your family or primary care physician? _____

Were you referred to our office by this or any other physician? (please give name) _____

Please list other family members in our practice _____

Emergency contact & relationship _____ Phone # _____

PARENT AND/OR RESPONSIBLE PARTY (if different from patient)

If patient is a minor please give both parent's names, dates of birth, and Social Security numbers:

_____

_____

If there is a custody or guardianship situation, who is the custodial parent (full or part-time) or guardian? _____

_____

Who is responsible for any unpaid balance after insurance has been filed?

Name _____ Relationship to patient _____

Address & phone number (if different from patient): _____

PRIMARY INSURANCE Cardholder's name _____ Relationship to patient _____

Employer _____ Date of birth _____ Social Security # _____

Insurance company name _____ Effective date _____

SECONDARY INSURANCE Cardholder's name _____ Relationship to patient _____

Employer _____ Date of birth _____ Social Security # _____

Insurance company name _____ Effective date _____

I understand I am responsible for any balance my insurance company does not pay. (Please sign & date below)

_____

(PATIENT/RESPONSIBLE PARTY SIGNATURE) (DATE)

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HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information. You have the right to review our notice before signing this consent. As provided in our notice, the terms could change. If any changes are made, you may obtain a copy from the receptionist.

If there is anyone you would like to designate/permit us to release your protected health information to, please list below. An example would be a spouse, step-parent, non-custodial parent, child, or other family member calling in for a test result. If someone is not listed, we cannot discuss your care with them.

_____
List Designated Person & Relationship

_____
List Designated Person & Relationship

_____
List Designated Person & Relationship

_____
List Designated Person & Relationship

_____
List Designated Person & Relationship

_____
Patient Signature Guardian Signature (if pt is under 18)

_____
Print Name Patient DOB

_____
Witness Signature Date

Allergy Associates, P.C.
Condition of Services

Statement to Permit Payment of Medicare Benefits: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Allergy Associates, P.C., including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid services and its agents any information needed to determine these benefits or benefits for related services.

Assignment of Insurance Benefits/Release of Information: I hereby assign all medical benefits to which I am entitled including Medicaid, private insurance and other health plans to Allergy Associates. I understand that I am financially responsible to the treating health care provider for charges not covered by this authorization. Should my account be referred to collections, I understand I could be charged attorney and collection fees. I also authorize the release of health information as needed for payment purposes. I am aware that if I do not pay my bill as determined by my insurance company, my account will be assessed a collection fee and sent to a collection agency.

Photographs: I hereby authorize Allergy Associates to take a picture of me and use it for identification purposes only.

Consent to Treatment: I hereby authorize the physicians of Allergy Associates to treat me medically as necessary. This includes routine visits, illnesses, allergy injections and potential reactions.

If the patient is a minor:
I do hereby give consent for _____ to be treated by Allergy Associates including in the event of my absence. This includes office visits, the treatment of illness and for allergy injections and potential reactions.

_____
Parent/Guardian Signature

I have read and understand the above statements. Date: _____

_____
Patient Name (Please Print) Patient/Guardian Signature

_____
Medicare only: Beneficiary Name HICN (Medicare Number)