Phone 402.391.1800 **ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.** allergynebraska.com

NEW PATIENT WELCOME LETTER AND APPOINTMENT INFORMATION

Welcome

Thank you for choosing Allergy, Asthma & Immunology Associates. Your care begins here, led by our board-certified physicians who provide specialized expertise across the full spectrum of allergy and immune health. To ensure a thorough and personalized evaluation, your initial visit may last **one to three hours**.

Appointment Details

Refer to your email or see appointment details below.

Appointment with James M. Tracy, DO James L. Friedlander, MD Robert Szalewski, MD Mitchell M. Pitlick, MD

Appointment Date/Time a.m. p.m.

Appointment Location

AAIA Clinic Addresses

Omaha (Main Office):
2808 S. 80th Ave., Ste. 210, Omaha, NE 68124

Nebraska Locations:

Lakeside: 17030 Lakeside Hills Pz., Ste. 218, Omaha, NE 68130

Fremont: 401 E. 22nd St., Ste. 1, Fremont, NE 68025

Papillion: 401 E. Gold Coast Rd., Ste. 331, Papillion, NE 68046

Gretna: 20710 Schofield Dr., Ste. 103, Gretna, NE 68022

Columbus: 4508 38th St., Ste. 210, Columbus, NE 68601

Valentine: 510 N. Green St., Valentine, NE 69201

Iowa Locations:

Council Bluffs: 3434 W. Broadway St., Council Bluffs, IA 51501

Harlan: 1213 Garfield Ave., Harlan, IA 51537

Sioux City: 4301 Sergeant Rd., Ste. 215, Sioux City, IA 51106

Medicines to Stop Before Allergy Testing

If you are having allergy testing, please stop taking antihistamines for seven (7) full days before your appointment. Examples include, but are not limited to, the following antihistamines:

- Loratadine (Claritin, Alavert)
- Cetirizine (Zyrtec)
- Diphenhydramine (Benadryl)
- Olapatadine (Patanase)
- Levocetirizine (Xyzal)
- Desloratadine (Clarinex)
- Fexofenadine (Allegra)
- Nizatidine (ex: Axid)
- Hydroxyzine (Atarax)
- Meclizine (Antivert, Bonine)
- Azelastine nasal spray (Astelin)
- Acid-reducing (H2) medications: Famotidine (Pepcid), Cimetidine (Tagamet), Ranitidine (Zantac)

This list is not exhaustive. If you are unsure whether a medication is an antihistamine, please ask your pharmacist or contact our office before your appointment.

Do not stop taking any other medications, including asthma medications.

Typical Initial Visit Fee and Testing Costs

Typical fees and services associated with an initial visit include, but are not limited to, the following:

- Initial evaluation: $400.00 (CPT 99204)
- Skin testing (Complex allergy evaluations may require up to 75 tests):
  - $15.00 per scratch test (CPT 95004)
  - $20.00 per intradermal test (CPT 95024)
- Lung function testing: $80.00–$200.00

Evaluations, testing, and procedures are performed to inform and guide your care; however, in some circumstances, your healthcare provider may determine that testing is not indicated. Please inform your provider in advance if you prefer not to have a specific test performed. Fees apply to all services rendered and remain payable regardless of whether test results are positive or negative. Our fees are subject to change. Please confirm coverage with your insurer(s) and read our **Financial Matters** policy for additional billing, payment, and patient responsibility details.

Before Your Appointment

- Complete and sign all forms in your packet and/or in the portal
- Review and sign the **Financial Matters** policy
- Bring all insurance cards (primary, secondary, tertiary)
- Bring payment for your specialist co-pay (or $200 if no insurance/not filing to insurance)
- Arrive **15 minutes early**

We submit insurance claims as a courtesy. If you choose to file your own claim, full payment is due at the time of service. Medicare and Medicaid claims are submitted automatically.

Any remaining balance after insurance processing is due upon receipt of your statement. We accept cash, checks, and credit/debit cards. Payment plans are available - please call our Billing office for details.

Appointment Cancellations

If you are unable to keep your appointment, please notify us at **(402) 391-1800** at least **24 hours in advance**, even if you cancel via text; this allows us to offer the appointment to another patient.

Please contact us if you have any questions. We look forward to caring for you.

Warm Regards,

The Physicians and Team of
Allergy, Asthma & Immunology Associates, P.C.

Board Certified in Allergy/Immunology
Members of the American Academy of Allergy, Asthma & Immunology
Members of the American College of Allergy, Asthma & Immunology

ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.

PATIENT DEMOGRAPHIC FORM / FORMULARIO DEMOGRÁFICO DEL PACIENTE

DATE / FECHA _____

PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE

_____

FIRST NAME / NOMBRE DE PILA **M.I. / INICIAL** **LAST NAME / APELLIDO**

_____

HOME ADDRESS / DIRECCIÓN **CITY / CIUDAD** **STATE / ESTADO** **ZIP / CÓDIGO POSTAL**

_____

EMAIL ADDRESS / CORREO ELECTRÓNICO **SOCIAL SECURITY # / SEGURIDAD SOCIAL #**

_____

DATE OF BIRTH / FECHA DE NACIMIENTO **AGE / EDAD** **PREFERRED NAME/NICKNAME / NOMBRE PREFERIDO/APODO**

	☐ CELL / CEL ☐ HOME / CASA		☐ CELL / CEL ☐ HOME / CASA
PRIMARY PHONE / TELÉFONO PRIMARIO	☐ WORK / TRAB.	**SECONDARY PHONE / TELÉFONO SECUNDARIO**	☐ WORK / TRAB.

GENDER/GÉNERO ☐ MALE / MASCULINO ☐ FEMALE / FEMENINO

_____
PREFERRED LANGUAGE / IDIOMA DE PREFERENCIA

INTERPRETER NEEDED? ☐ YES ☐ NO
¿NECESITAS INTÉRPRETE? ☐ SÍ ☐ NO

RACE / RAZA
☐ WHITE / BLANC ☐ BLACK/AFRICAN AMERICAN / NEGRO/AFROAMERICANO
☐ HISPANIC / HISPANO ☐ AMERICAN INDIAN/ALASKAN NATIVE / INDÍGENA AMERICANO/NATIVO DE ALASKA
☐ ASIAN / ASIÁTICO ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER / NATIVO DE HAWÁI/OTRAS ISLAS DEL PACÍFICO

MARITAL STATUS / ESTADO CIVIL
☐ MARRIED / CASADO(A) ☐ SINGLE / SOLTERO(A) ☐ LEGAL SEPARATION / SEPARACIÓN LEGAL
☐ LIFE PARTNER / PAREJA DE HECHO ☐ DIVORCED / DIVORCIADO(A) ☐ WIDOWED / VIUDO(A)

EMERGENCY CONTACT/NEXT OF KIN / CONTACTO DE EMERGENCIA/FAMILIAR CERCANO

_____

EMERGENCY CONTACT FULL NAME / NOMBRE COMPLETO DEL CONTACTO DE EMERGENCIA **PHONE NUMBER / NÚMERO DE TELÉFONO**

_____

RELATIONSHIP TO PATIENT / RELACIÓN CON EL PACIENTE

REPRESENTATIVE AUTHORIZATION (IF APPLICABLE) / AUTORIZACIÓN DEL REPRESENTANTE (SI CORRESPONDE)

PARENT OR GUARDIAN #1 / PADRE O TUTOR #1

_____ _____
NAME / NOMBRE **DOB / DATA DE NACIMIENTO**

_____ _____
ADDRESS / DIRECCIÓN **PHONE /TELÉFONO**

_____ _____
RELATIONSHIP TO PATIENT / RELACIÓN CON EL PACIENTE **SSN# / SEGURIDAD SOCIAL #**

FINANCIALLY RESPONSIBLE PARTY? / ¿RESPONSABLE DE PAGO? ☐ YES / SÍ ☐ NO

PARENT OR GUARDIAN #2 / PADRE O TUTOR #2

_____ _____
NAME / NOMBRE **DOB / DATA DE NACIMIENTO**

_____ _____
ADDRESS / DIRECCIÓN **PHONE /TELÉFONO**

_____ _____
RELATIONSHIP TO PATIENT / RELACIÓN CON EL PACIENTE **SSN# / SEGURIDAD SOCIAL #**

FINANCIALLY RESPONSIBLE PARTY? / ¿RESPONSABLE DE PAGO? ☐ YES / SÍ ☐ NO

LEGAL AUTHORITY / AUTORIDAD ☐ #1 ☐ #2 ☐ JOINT / CONJUNTA

IF PATIENT REQUIRES MEDICAL CARE OR TREATMENT WHEN I AM NOT PRESENT AT THE CLINIC, I AUTHORIZE AAIA TO PROVIDE CARE AS DEEMED NECESSARY. / SI EL PACIENTE NECESITA ATENCIÓN MÉDICA O TRATAMIENTO CUANDO NO ESTOY PRESENTE EN LA CLÍNICA, AUTORIZO A AAIA A PROPORCIONAR ATENCIÓN SEGÚN SE CONSIDERE NECESARIO.

_____ _____ _____
REPRESENTATIVE SIGNATURE / FIRMA DEL REPRESENTANTE **RELATIONSHIP / PARENTESCO** **DATE / FECHA**

ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.

PATIENT DEMOGRAPHIC FORM / FORMULARIO DEMOGRÁFICO DEL PACIENTE

PATIENT NAME / NOMBRE DEL PACIENTE_____

YOUR REFERRING & PRIMARY PROVIDERS / TU PROVEEDOR DE REFERENCIA Y PRINCIPALESA

☐ **CHECK IF PROVIDERS ARE THE SAME / MARQUE SI ES EL MISMO PROVEEDOR**

_____

REFERRING PROVIDER NAME, PHONE, ADDRESS / MÉDICO REMITENTE: NOMBRE, TEL. Y DIR.

_____

PRIMARY CARE PROVIDER NAME, PHONE, ADDRESS / MÉDICO CABECERA: NOMBRE, TEL. Y DIR.

INSURANCE INFORMATION / INFORMACIÓN DEL SEGURO

☐ **CHECK IF PATIENT DOES NOT HAVE MEDICAL INSURANCE / MARQUE SI NO TIENE SEGURO MÉDICO**

PRIMARY INSURANCE (IF APPLICABLE) / SEGURO PRIMARIO

_____

PRIMARY INSURANCE COMPANY / COMPAÑÍA DE SEGURO PRIMARIO

_____ _____

POLICY NUMBER / NÚMERO DE PÓLIZA **GROUP # / GRUPO #**

_____

SUBSCRIBER'S FULL NAME & DATE OF BIRTH / NOMBRE COMPLETO Y FECHA DE NACIMIENTO DEL SUSCRIPTOR

SUBSCRIBER'S RELATIONSHIP TO PATIENT / RELACIÓN DEL SUSCRIPTOR CON EL PACIENTE ☐ **SELF / YO** ☐ **SPOUSE / CÓNYUGE** ☐ **PARENT / PADRE-MADRE** ☐ **OTHER / OTRO**

SECONDARY INSURANCE (IF APPLICABLE) / SEGURO SECUNDARIO (SI CORRESPONDE)

_____

SECONDARY INSURANCE COMPANY / COMPAÑÍA DE SEGUROS SECUNDARIA

_____ _____

POLICY NUMBER / NÚMERO DE PÓLIZA **GROUP # / GRUPO #**

_____

SUBSCRIBER'S FULL NAME & DATE OF BIRTH / NOMBRE COMPLETO Y FECHA DE NACIMIENTO DEL SUSCRIPTOR

SUBSCRIBER'S RELATIONSHIP TO PATIENT / RELACIÓN DEL SUSCRIPTOR CON EL PACIENTE ☐ **SELF / YO** ☐ **SPOUSE / CÓNYUG** ☐ **PARENT / PADRE-MADRE** ☐ **OTHER / OTRO**

MORE THAN TWO PLANS? PLEASE TELL STAFF. / ¿MÁS DE DOS PLANES? POR FAVOR, DÍSELO AL PERSONAL.

PLEASE READ AND SIGN / POR FAVOR LEA Y FIRME

I HEREBY AUTHORIZE ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C. (AAIA), TO FURNISH INFORMATION REGARDING MY OR MY CHILD'S HEALTH AND TREATMENT TO THE INSURANCE COMPANY(S). / POR LA PRESENTE AUTORIZO A ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C. (AAIA) A PROPORCIONAR INFORMACIÓN SOBRE MI SALUD O LA DE MI HIJO(A) A LA(S) COMPAÑÍA(S) DE SEGUROS.

_____ _____

P**ATIENT/RESPONSIBLE PARTY SIGNATURE/FIRMA DEL PACIENTE/PARTE RESPONSABLE** **DATE / FECHA**

MEDICARE AUTHORIZATION / AUTORIZACIÓN DE MEDICARE

I AUTHORIZE MEDICARE PAYMENTS DIRECTLY TO AAIA / AUTORIZO PAGOS DE MEDICARE DIRECTAMENTE A AAIA

_____ _____

MEDICARE AUTHORIZATION SIGNATURE / FIRMA **DATE / FECHA**

NOTICE OF PRIVACY PRACTICES / AVISO DE PRÁCTICAS DE PRIVACIDAD

AAIA IS COMMITTED TO PROTECTING YOUR MEDICAL INFORMATION. A COPY OF OUR FULL NOTICE OF PRIVACY PRACTICES IS AVAILABLE AT OUR FRONT DESK AND ON OUR WEBSITE. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. / AAIA ESTÁ COMPROMETIDA A PROTEGER TU INFORMACIÓN MÉDICA. UNA COPIA COMPLETA DE NUESTRO AVISO DE PRÁCTICAS DE PRIVACIDAD ESTÁ DISPONIBLE EN NUESTRA RECEPCIÓN Y EN NUESTRA PÁGINA WEB. ESTE AVISO DESCRIBE CÓMO PUEDE UTILIZARSE Y DIVULGARSE LA INFORMACIÓN MÉDICA SOBRE TI Y CÓMO PUEDES ACCEDER A ESTA INFORMACIÓN.

CO-PAY AND REFERRAL NOTICES / COPAGO Y AVISOS DE DERIVACIÓN

- ALL CO-PAYMENTS ARE COLLECTED AT THE TIME OF YOUR VISIT. / TODOS LOS COPAGOS SE COBRAN AL MOMENTO DE SU CITA.
- IF REFERRAL REQUIRED, WE NEED IT AT LEAST 2 DAYS IN ADVANCE. / SI ES NECESARIO LA DERIVACIÓN, LA NECESITAMOS CON AL MENOS 2 DÍAS DE ANTELACIÓN.

Phone 402.391.1800 **ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.** allergynebraska.com

PATIENT PRIVACY AND COMMUNICATION ACKNOWLEDGMENT AND CONSENTS

Patient name _____ **Date of birth** _____

Use and Disclosure of Health Information

To provide and coordinate my care, I understand that the clinic may use or share my health information for the following purposes:

- **Treatment:** Coordination of care among healthcare providers
- **Payment:** Billing, claims submission, and insurance verification
- **Healthcare Operations:** Quality improvement, compliance, audits, and administrative functions

My Rights

I understand that I have the right to:

- Request restrictions on the use or disclosure of my health information (not guaranteed)
- Inspect and request copies of my medical records
- Request corrections or amendments
- Receive an accounting of certain disclosures
- Revoke this consent in writing, except where action has already been taken

Authorized Contacts

Individuals we may speak with regarding your general medical information, billing and payment matters:

_____ _____
Name & relationship to patient Phone number

_____ _____
Name & Relationship to patient Phone number

Emergency Contact Only

Individuals we may contact only in an emergency:

_____ _____
Name & relationship to patient Phone number

_____ _____
Name & relationship to patient Phone number

Protected Health Information (PHI)

Protected Health Information (PHI) may include medical, appointment, test, referral, and billing information. I understand that this authorization is voluntary, may be revoked in writing, and does not affect my ability to receive treatment. Information disclosed may be subject to redisclosure and may no longer be protected under HIPAA. Additional details are available in the Notice of Privacy Practices.

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have access to this clinic's Notice of Privacy Practices (NPP), in person, on the clinic's website at www.allergynebraska.com, and by request, and the NPP explains how my protected health information (PHI) may be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Electronic and Phone Communications

Phone & Voicemail Communication

I understand that the clinic may contact me regarding my care using the following methods:

- Patient portal
- Email
- Telephone calls & voicemail
- Text messages

I understand that electronic communications are not always secure and may involve privacy risks. I may request alternative communication methods in writing.

☐ YES – I authorize the clinic to leave detailed information (including treatment plans, referrals, test results, and billing information) on my voicemail and/or with designated family members.

☐ NO – I do not authorize the clinic to leave detailed information as described above.

Note: Basic appointment information (date, time, and location) may still be left in accordance with HIPAA.

Text Message Communication Consent

Check one

☐ YES – I consent to receive non-marketing healthcare text messages from the clinic at the mobile number on file. Messages may include appointment reminders, scheduling updates, billing notices, and general healthcare information.

☐ NO – I do NOT consent to receive text messages from the clinic.

I understand that:

- Text messages are not encrypted
- Message and data rates may apply
- My consent is not required to receive care
- I may withdraw consent at any time by notifying the clinic or replying “STOP”

Telehealth Consent (Only If Telehealth Is used)

Telehealth services may be provided on a limited basis. Participation is voluntary, and I may refuse or discontinue telehealth services at any time without affecting my right to future care. I understand that the same privacy and confidentiality protections apply as with in-person services. I consent to telehealth services if provided.

Acknowledgment and Signature

I understand that this consent remains in effect unless revoked in writing. No separate authorization is required for uses and disclosures related to treatment, payment, or healthcare operations, as permitted by law.

Print patient name _____

Legal representative name/relationship _____
(If not the patient)

Patient or legal representative signature _____

Date _____

Phone 402.391.1800 ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C. allergynebraska.com

FINANCIAL MATTERS POLICY

Patient Name _____ **Date of Birth** _____

Thank you for choosing Allergy, Asthma & Immunology Associates, P.C. (AAIA).

A clear understanding of our Financial Matters is important to our professional relationship. Please review this document in its entirety.

- We must emphasize that as your healthcare providers, AAIA's professional relationship is with you, not your insurance provider**.** Filing your insurance claims is a courtesy we extend to our patients, but it is often necessary for you to inquire and explore your benefits with your insurance provider. The patient is responsible for any portion of the charges deemed non-covered or noted as "Patient Responsibility".
- AAIA is a private practice (independent) clinic. AAIA is not directly affiliated with outside laboratories, clinics, pharmacies, or physicians. When AAIA providers order lab tests, AAIA is not responsible for charges, fees and bills from labs or services outside of AAIA.

  AAIA reminds new and established patients that you must:

  - Check with your specific insurance plan to determine which of AAIA's physicians and locations are "in-network" for your benefits.
  - Check in advance with your insurance plan to determine coverage and exclusions.
  - Check in advance with laboratories, non-AAIA physicians, and pharmacies to understand the services, charges, and patient financial obligations that you will have with the non-AAIA entities.
- Patients must present current insurance card(s) at each visit. If you do not have your insurance card(s) at the time of your appointment, you will be billed as self-pay and will be responsible for the full balance. Please note that patients remain responsible for any charges not covered by insurance.
- If you do not have insurance coverage or your charges are subject to a large yearly deductible:
  - A minimum down payment of **$200.00** towards the balance is expected at the time of your visit if you are a **NEW** patient.
  - A minimum down payment of **$100.00** towards the balance is expected at the time of your visit if you are **an ESTABLISHED** patient. Our fees are subject to change.
- Uninsured/self-pay patients**:** per the No Surprises Act of 2022, if you would like a Good Faith Estimate of the costs for services/procedures anticipated to be rendered, please contact our Billing office. Additionally, our Billing office will contact you to establish a formal payment plan for the remaining balance.
- Our office files all insurance claims; however, we may not be "in-network" or "participating providers" with all insurance plans. It is your responsibility to check with your insurance provider before your visit to see if AAIA is in-network with your plan. Services listed as "covered" by your plan are still subject to the patient's financial liability for deductibles, co-insurance, and co-payments (as outlined in your plan).
- To evaluate and accurately diagnose your condition, we may perform allergy tests and other tests or procedures. Please understand that payment for these services is required, regardless of the test outcome.
- The providers at our clinic are categorized as specialists. Please note this fact when referring to your insurance plan benefits, coverage, and co-pay amounts.
- All co-payments are due at the time of service, including injection patients who have co-payment/co-insurance payments associated with each administered injection (administration CPT code).

- **If your insurance provider requires a referral** (such as for Tricare Prime members), you are responsible for obtaining a referral to our office from your Primary Care Physician (PCP). **This referral must be secured at least 48 hours before your scheduled appointment.** Following insurance guidelines, we cannot provide services without prior authorization. Please have your referring physician fax the referral to our office at (402) 391-1563 or call (402) 391-1800.
- Once your insurance provider has processed your claim, you will receive a billing statement from AAIA reflecting your patient responsibility for any remaining balance due.
    - Payment in full is expected when you receive your statement. Cash and checks are accepted in person at all locations. Checks or credit card payments may be mailed to our Billing office:

      AAIA ATTN BILLING
      2808 S 80TH AVE STE 210
      OMAHA NE 68124

    - Payments by credit card (Visa®/MasterCard®/Discover®/American Express®) are accepted in person or over the phone by calling our Billing office at (402) 391-1800.
    - If you are unable to pay your balance in full at the time you receive your statement, please call and speak with one of our Billing employees to set up a monthly payment plan.
    - **A $50.00 Service Fee** will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pay for the services by cash, money order, or credit card.
- **Throughout this policy, all references to patient responsibility for payment and financial obligations apply to the patient, their guarantor, or their legal guardian.**

I understand and agree to the terms of the Financial Matters Policy.

Print patient name _____

Print responsible party name (if not patient) _____

Relationship to patient (if applicable) _____

Signature of patient or responsible party _____

Date _____