Dr. Jason Paris, MD

37650 Professional Center Dr.
Suite 105A
Livonia, MI 48154
Tel 734-591-6660
Fax 734-744-8514

609 W. Main St.
Brighton, MI 48116
Tel 810-229-2887
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Paris
ASTHMA & ALLERGY CENTERS

Dear New Patient:

Paris Asthma and Allergy Centers thanks you for selecting Dr. Jason C. Paris, MD as your allergist.

Your inital new patient appointment is scheduled for: _____

In order to save you time on your first visit, we have enclosed several forms for you to complete. Please completely answer all requested information on the following patient information forms. Please sign all forms where indicated and bring the completed forms with you on the day of your appointment. Also, be sure to complete the online health questionnaire emailed to you before your scheduled appointment.

You should plan to be here for at least two hours. We ask that you do not take any antihistamines seven days before your appointment time, as it may suppress the skin test reaction. Antihistamines include Benadryl, Zyrtec, Claritin, Allegra, Xyzal and some sleep aids. If you have been taking Atarax, you need to be off the Atarax five days prior to skin testing. If you are talking antidepressants or steroids please let the office know as some may need to be halted for five days. Skin testing can be scheduled for a later time if this restriction is an inconvenience. If you have any questions regarding medications you are taking, please call the office. Please plan to eat before your appointment. If you wear contact lenses, please bring some solution and your contact lens case with you. Bring copies of any recent lab work results with you to the appointment. **AND Please help us keep our office a scent- free zone. Avoid wearing perfumes, colognes and aftershaves to the office.**

We do not participate with all insurances nor do all plans cover allergy care. Please verify your allergy coverage with your insurance plan as it relates to allergy treatment before the time of your visit. We do not see HAP patients who are in the Henry Ford, Genesys, or DMC network. The initial consultation fee is $225. Skin testing and other fees can exceed $500. If you have not met your deductible for the year you will be required to pay $200 at the time of service. We will courtesty bill non-participating insurances but the patient is still responsible for any follow up on claims. Patients who have insurance with which we participate are responsible for any co-pays, deductibles, services not covered by their plan and any necessary referrals. We accept cash, checks, Visa, Mastercard, Discover and American Express.

Since cancellations are an inconvenience to other patients as well as our office staff, we ask that you give 24-hour notice if you need to cancel or reschedule your appointment. If you fail to keep your appointment or cancel the day of your appointment, you will be charged $30.

Please contact us with any questions or concerns you may have. We look forward to having you as a patient!

Sincerely,

Dr. Jason C. Paris, MD and the staff of Paris Asthma and Allergy Centers

MEDICATIONS & ALLERGY TESTS

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MEDICATIONS & ALLERGY TESTS

There are many different allergy medications that will affect skin testing. If you are taking something NOT on this list and you are not sure, please call the office. DO NOT STOP taking your asthma or other routine medications, such as medications that treat blood pressure, diabetes, etc.

ANTIHISTAMINES - Discontinue **7 days** prior to your testing appointment:

Allegra or Allegra D (fexofenadine)
Antivert (meclizine)
Astelin nasal spray (azelastine)
Atarax (hydroxyzine HCL)
Clarinex (desloratadine)
Claritin or Claritin D (loratadine)
Clemastine (tavist)
Doxepin
Optivar (azelastine) eye drop
Periactin (cyproheptadine)
Phenergan (promethazine)
Vistaril (hydrozyzine)
Xyzal (levocetirizine)
Zyrtec or Zyrtec D (cetirizine)
Hismanal (astemizole)

COLD & FLU MEDICATIONS - Discontinue **3 days** prior to your testing appointment.
Read the ingredient labels on all medications, particularly over the counter sinus, cold or flu medication for any of the following ingredients:

Acrivastine
Azatadine
Benadryl
Brompheniramine
Carbinozamine
Chlorpheniramine
Diphenhydramine
Methscopolamine
Phenindamine
Pyrilamine

EYE DROPS - Discontinue **3 days** prior to your testing appointment:

Alomide eye drop
Livosten eye drop
Naphcon-A eye drop
Pataday
Pazeo
Optron-A eye drop
Patanol eye drop
Visine

ANTIDEPRESSANTS - Discontinue **7 days** prior to your testing appointment.

Amitriptyline
Clomipramine
Doxepin
Imipramine
Desipramine
Nortyptyline
Protryptyline

HERBAL SUPPLEMENTS - Discontinue **3 days** prior to testing appointment.
Licorice - Green Tea - Saw Palmetto - St. John's Wort - Feverfew

PREDNISONE should NOT be taken **3 days** prior to testing.

PATIENT INFORMATION / DEMOGRAPHICS

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PATIENT INFORMATION / DEMOGRAPHICS

Patient Name _____ Date _____

DOB _____ Maritial Status M S W S D Gender M F

Address _____ City _____ State _____

Zip _____ Mobile phone _____ Home phone _____

Email _____

Emergency Contact _____ Phone _____

Local Pharmacy _____ Cross roads _____

Mail Order Pharmacy _____

Briefly describe what symptoms brought you to our office:

_____
_____
_____
_____
_____

Primary doctor _____ Other _____

Referring doctor _____

List ALL medications including prescriptions, over the counter, vitamins and supplements:

Medication Dosage How often

_____
_____
_____
_____
_____
_____
_____
_____
_____

Continue on back

PATIENT INFORMATION / DEMOGRAPHICS CONT.

Are you allergic to any medications that you are aware of?

_____
_____

In the past 12 months, have you had any of the following:

Courses of oral steroids?	None	1	2	3+
ER visits due to asthma?	None	1	2	3+
Hospitalizations due to asthma?	None	1	2	3+

Have you ever had an ICU admission for asthma? Yes No When? _____

When was your last hospitalization for asthma? _____

Do you have a peak flow monitor at home? Yes No Personal best? _____

Authorizations

I authorize payment directly to Paris Asthma and Allergy Centers for services rendered. I understand I am financially responsible for any copayments, deductibles or other charges not covered by my insurance plan. I understand that I am responsible for services performed without a valid HMO authorization form from my primary care physician if my insurance requires one. I, also, understand that I am responsible to know my own insurance coverage.

Signature _____ Date _____

How did you hear about our office? Please circle all that apply.

Physician Insurance Patient Friend Family

Website Facebook Twitter Other _____

MEDICAL COMPLIANCE FORM

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MEDICAL COMPLIANCE FORM

Date _____

Patient Name _____ DOB _____

PLEASE ANSWER THE FOLLOWING

- Have you had a flu shot this year? No ____ Yes ____ Date ____ Where _____
- Have you had a pneumonia shot? No ____ Yes ____ Date ____ Where _____
- Do you smoke? No ____ Yes ____ How much? _____
- Former smoker? No ____ Yes ____ How long ago? _____
- Do you drink alcohol? No ____ Yes ____ How much & often? _____
- Do you take medication for high blood pressure? No ____ Yes ____
  If yes, name of medication? _____
- Have you had a colonoscopy? No ____ Yes ____ Date _____
- Do you have pain? No ____ Yes ____ Where & how long? _____
- Do you have asthma? No ____ Yes ____
  If yes, is it well controlled? No ____ Yes ____
  What are your asthma triggers? _____
- Do you have diabetes? No ____ Yes ____
  If yes, how is it controlled? _____
- Do you have a care plan in case you become incapacitated?
  If yes, name and relationship _____

FOR WOMEN ONLY

- Have you had cervical cancer screening (Pap Smear)? No ____ Yes ____ Date _____
- Have you had breast cancer screening (Mammogram)? No ____ Yes ____ Date _____

MEDICATIONS PREVIOUSLY TRIED

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MEDICATIONS PREVIOUSLY TRIED

Patient Name _____ DOB _____

To treat my allergy symptoms, I have tried:
PLEASE CHECK ALL THAT APPLY

Antihistamines

____ Allegra/Allegra D
____ Benadryl
____ Claritin/Claritin D
____ Clarinex
____ Xyzal
____ Zyrtec
____ Singulair
____ Other

Nasal Sprays

____ Afrin
____ Flonase
____ Nasacort AQ
____ Nasonex
____ Omnaris
____ Rhinocort Aqua
____ QNasal
____ Veramyst
____ Other

Inhalers

____ Advair
____ Albuterol
____ Arnuity Ellipta
____ Asmanex
____ Breo
____ Combivnet
____ Dulera
____ Flovent
____ Pro Air
____ Proventil
____ Pulmicort
____ QVar
____ Serevent
____ Spiriva
____ Symbicort
____ Ventolin
____ Other

Eye Drops

____ Bepreve
____ Pataday
____ Patanol
____ Zaditor
____ Optivar
____ Opcon
____ Alaway
____ Pazeo
____ Other

Others:

_____
_____
_____
_____
_____
_____
_____
_____

NOTICE OF HIPAA PRIVACY PRACTICE

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICE

By signing below, I acknowledge that I have received or was offered a copy of the Paris Asthma & Allergy Center Notice of Privacy Practice form.

Patient name _____ DOB _____
Please print clearly

NOTICE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please indicate if there is a family member or friend to whom we are allowed to release medical information to either hard copy or electronically.

Name _____ Phone _____

Name _____ Phone _____

Please indicate if there are any restrictions to the disclosure of your protected health information below.

_____
_____
_____

Please note that we may be sharing your medical information with other doctors. _____ (initial)

Signature _____ Date _____

CANCELLATION & NO SHOW POLICY

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CANCELLATION & NO SHOW POLICY

Regular attendance of appointments is important for the success of your treatment. Frequently No Show or missed appointments drive up cost for everyone. Furthermore, each missed appointment is a missed opportunity to care for others who also need treatment. Your cooperation in keeping scheduled appointments, and cancellation in a timely manner when necessary, is appreciated.

To minimize the number of No Show or missed appointment, it is necessary for Paris Astha and Allergy Centers to institute the following policy. Effective immediately, the following provisions are in effect:

- Failure to keep a scheduled appointment without advanced cancellation will result in a $30 charge.
- Appointments can be cancelled or rescheduled for any reason with at least a 24 hour notice, but as much advance notice as possible is greatly appreciated. PLEASE INFORM OUR OFFICE IF YOU CANNOT ATTEND YOUR SCHEDULED APPOINTMENT.

If you speak with a staff member, please be sure to note their name and date that you called the office. If you do not speak with a staff member, please be sure to leave a message on our voicemail.

Your signature below indicates that you have read and understand the Paris Asthma and Allergy Centers' "No Show" policy and agree to its terms. This policy includes all future appointments.

_____
Print patient name

_____ _____
Patient/Guarantor Signature Date

_____ _____
Witness Signature (PAC employee) Date