

609 W. Main Street  
Brighton, MI 48116  
(P) 810-229-2887  
(F) 810-229-5560



16801 Newburgh Rd. Ste 106  
Livonia, MI 48154  
(P) 734-591-6660  
(F) 734-744-8514

Dear New Patient:

Paris Asthma and Allergy Centers thanks you for selecting Jason Paris M.D. as your Allergist.

In order to save you time on your first visit, we have enclosed forms for you to complete. Please circle or fill in the blanks on the personal history form. Please sign the New Patient Information Sheet where indicated and bring the completed forms with you on the day of your appointment with your insurance card and id.

Your Initial Consultation is scheduled for \_\_\_\_\_.

You can expect to be here for at least (2) hours. We ask that **you do not take any antihistamines, one week** before your appointment time, as it may suppress the skin test reaction. If you have been taking **Atarax**, you need to be off the Atarax 5 days prior to skin testing. 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 our office. Please plan to eat before your appointment. Please help us keep our office a scent-free zone by refraining from wearing perfumes, colognes and after shaves to the office. Also, please bring copies of any recent lab work results with you to the appointment.

We do not participate with all insurances nor do all plans cover allergy care. Please verify your insurance coverage 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 require payment of any copays or deductibles on the day of service.** We will courtesy bill non-par 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 checks, Visa/Master card, Discover, and American Express or cash.

**Since cancellations are an inconvenience to other patients as well as our office staff, we ask that you give a 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 \$100.**

We look forward to having you as a patient!

PARIS ASTHMA AND ALLERGY CENTERS

## **Information to bring to your appointment**

1. Driver's License
2. All insurance cards
3. A list of all medications you are currently taking
4. Lab/blood work results done within the last 6 months that wasn't ordered through our office
5. Name, address and phone number of your primary care doctor
6. Name, address and phone number of your pharmacy

## Paris Asthma & Allergy Centers

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PH: 810-229-2887  
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### Medications Effecting Allergy Testing

There are many different allergy medications that will effect skin testing. If you are taking something **NOT** on this list and you are not sure, please call the office.

1. Discontinue these antihistamines 7 days prior to your testing appointment:

Allegra or Allegra D (fexofenadine)	Optivar (azelastine) eye drop
Antivert (meclizine)	Periactin (cyproheptadine)
Astelin nasal spray (azelastine)	Phenergan (promethazine)
Atarax (hydroxyzine HCL)	Vistaril (hydroxyzine)
Clarinex (desloratadine)	Xyzal (levocetirizine)
Claritin or Claritin D (loratadine)	Zyrtec or Zyrtec D (cetirizine)
Clemastine (tavist)	Hismanal (astemizole)
Doxepin	
2. Stop taking these antihistamines, cold & flu preparation 3 days prior to your testing appointment. Read the ingredient labels on all medications, particularly over the counter "sinus", "cold" or "flu" medications for any of the following ingredients.

Acrivastine	Chlorpheniramine
Azatadine	Diphenhydramine
Benadryl	Methscopolamine
Brompheniramine	Phenindamine
Carbinoxamine	Pyrilamine
3. Stop using these eye drops 3 days prior to your appointment:

Alomide eye drop	Pataday	Optron-A eye drop (OTC)
Livosten eye drop	Pazeo	Patanol eye drop
Naphcon-A eye drop (OTC)		Visine (OTC)
4. Some antidepressants interfere with allergy testing. Stop taking these 7 days before your test.

Amitriptyline	Imipramine	Nortyptiline
Clomipramine	Desipramine	Protryptiline
Doxepin		
5. The following herbal supplements should be discontinued 3 days prior to testing:  
Licorice, Green tea, Saw Palmetto, St. John's Wort, and Feverfew
6. Prednisone should **NOT** be taken 3 days prior to testing.
7. Nasal Sprays (except Astelin) may be continued.
8. Asthma medications, including Singulair, should be continued.

**\*\*DO NOT\*\*** stop taking your other routine medications, such as medications that treat blood pressure, asthma, diabetes etc



**Patient Information/Demographics**

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_\_\_ Marital Status M S W D P Gender M/F \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Mail order Pharmacy \_\_\_\_\_

Local Pharmacy \_\_\_\_\_ Cross roads \_\_\_\_\_

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

Physician Insurance Patient Friend Family Yellow pages Website Other

Briefly describe what symptoms brought you here \_\_\_\_\_

\_\_\_\_\_

Doctors: Primary Care \_\_\_\_\_ Referring Doctor \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Is insured a patient Yes No

Insured Date of Birth \_\_\_\_\_ Insurance Company Name \_\_\_\_\_

Policy number \_\_\_\_\_ Group Number \_\_\_\_\_

Patients relation to insured Self Spouse Child Other \_\_\_\_\_

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Is insured a patient Yes No

Insured Date of Birth \_\_\_\_\_ Insurance Company Name \_\_\_\_\_

Policy number \_\_\_\_\_ Group Number \_\_\_\_\_

Patients relation to insured Self Spouse Child Other \_\_\_\_\_

List all current medications (prescription and over the counter)

Medication

Dose

How often do you take it

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Are there allergies to any medications that you are aware of? \_\_\_\_\_

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In the past 12 months, how many:

Courses of oral steroids?	None	1	2	3+	Have you <b>EVER</b> had an <b>ICU</b> admission for asthma	Yes	No	When?
ER visits due to asthma	None	1	2	3+	When was your <b>last</b> hospitalization for asthma			When?
Hospitalizations due to asthma	None	1	2	3+	Do you have a peak flow monitor at home?	Yes	No	Personal Best?

**Authorizations**

I authorize payment directly to Paris Asthma & Allergy Centers for services rendered. I understand I am financially responsible for any copayments, deductibles or other charges not paid 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 \_\_\_\_\_

**PARIS ASTHMA AND ALLERGY CENTERS**

Medical Compliance form

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING:**

Have you had a Flu shot this year? Yes \_\_\_\_\_ No \_\_\_\_\_

Date \_\_\_\_\_ Where \_\_\_\_\_

Have you had a pneumonia shot? Yes \_\_\_\_\_ No \_\_\_\_\_

Date \_\_\_\_\_ Where \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

Former smoker? \_\_\_\_\_ How long ago did you quit? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_ No \_\_\_\_\_

Do you take medication for high blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, medication name \_\_\_\_\_

Have you had a Colonoscopy? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

Do you have pain? Yes \_\_\_\_\_ No \_\_\_\_\_ Where \_\_\_\_\_ How long? \_\_\_\_\_

Do you have asthma? Yes \_\_\_\_\_ No \_\_\_\_\_

Is it well controlled? Yes \_\_\_\_\_ No \_\_\_\_\_

What are your asthma triggers? \_\_\_\_\_

Do you have diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how is it controlled? \_\_\_\_\_

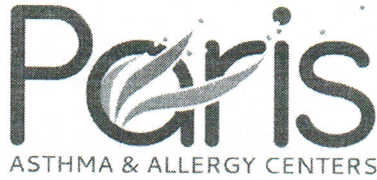
Do you have a care plan in case you become incapacitated? Yes \_\_\_\_\_ No \_\_\_\_\_

Who? (Relationship) \_\_\_\_\_

**Women only**

Have you had cervical cancer screening (Pap Smear)? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

Have you had Breast cancer screening (mammogram)? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_



## ACKNOWLEDGEMENT 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 Centers Notice of Privacy Practice form.

Name of Patient \_\_\_\_\_ DOB \_\_\_\_\_

Please print clear

### 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.

Restrictions \_\_\_\_\_

Please note that we may be sharing your medical information with other Doctors.

\_\_\_\_\_ (Initial)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient/Guardian



### **No Show Policy Acknowledgement**

Regular attendance of appointments is important for the success of your treatment. Frequently No Show (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 (missed) appointments, it is necessary for Paris Asthma and Allergy Centers (PAC) 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 understood the Paris Asthma and Allergy Centers "No Show" policy and agree to its terms. This policy includes all future appointments.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature (PAC employee)

\_\_\_\_\_  
Date



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**To treat my allergy symptoms I have tried (check all that apply)**

Antihistamines

- \_\_\_\_\_ Allergra/Allerga D
- \_\_\_\_\_ Bendaryl
- \_\_\_\_\_ Claritin/Claritin-D
- \_\_\_\_\_ Clarinex
- \_\_\_\_\_ Xyzal
- \_\_\_\_\_ Zyrtec
- \_\_\_\_\_ Singulair
- \_\_\_\_\_ Other

Nasal Sprays

- \_\_\_\_\_ Afrin
- \_\_\_\_\_ Flonase
- \_\_\_\_\_ Nasacort AQ
- \_\_\_\_\_ Nasonex
- \_\_\_\_\_ Omnaris
- \_\_\_\_\_ Rhinocort Aqua
- \_\_\_\_\_ Q Nasal
- \_\_\_\_\_ Veramyst
- \_\_\_\_\_ Xhance

Inhalers (Cont)

- \_\_\_\_\_ Pro Air
- \_\_\_\_\_ Proventil
- \_\_\_\_\_ Pulmicort
- \_\_\_\_\_ Q-Var
- \_\_\_\_\_ Serevent
- \_\_\_\_\_ Spiriva
- \_\_\_\_\_ Symbicort
- \_\_\_\_\_ Ventolin
- \_\_\_\_\_ Breztri
- \_\_\_\_\_ Trelegy
- \_\_\_\_\_ Alvesco
- \_\_\_\_\_ Other

Creams

- \_\_\_\_\_ Cortisone
- \_\_\_\_\_ Elidel
- \_\_\_\_\_ Elocon
- \_\_\_\_\_ Eucrisa
- \_\_\_\_\_ Nystatin
- \_\_\_\_\_ Protopic
- \_\_\_\_\_ Tricinolone
- \_\_\_\_\_ Bethamethasone
- \_\_\_\_\_ Other

Eye Drops

- \_\_\_\_\_ Bepreve
- \_\_\_\_\_ Pataday
- \_\_\_\_\_ Patanol
- \_\_\_\_\_ Zaditor
- \_\_\_\_\_ Optivar
- \_\_\_\_\_ Opcon
- \_\_\_\_\_ Alaway
- \_\_\_\_\_ Pazeo

Inhalers

- \_\_\_\_\_ Advair
- \_\_\_\_\_ Albuterol
- \_\_\_\_\_ Arnuity Ellipta
- \_\_\_\_\_ Asmanex
- \_\_\_\_\_ Breo
- \_\_\_\_\_ Combivnet
- \_\_\_\_\_ Dulera
- \_\_\_\_\_ Flovent