

Northern Michigan Allergy & Asthma Center, P.C.  
Timothy Linehan, M.D, Board Certified, Adult & Pediatric Allergy & Immunology  
405 North Division Road, Suite #4  
Petoskey, Michigan 49770

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Phone (231) 487-6575  
Fax (231) 439-9837



Dear Patient/Parent:

Welcome to Northern Michigan Allergy & Asthma Center, P.C.

We have enclosed pre-registration materials necessary for your appointment with Dr. Linehan. Please complete the forms and bring them with you to your appointment or fax them in advance to 231-439-9837. This information is an essential part of a complete allergy & asthma assessment. We reserve the right to cancel and reschedule your appointment if you arrive late or have not completed the necessary forms **in advance** of your reserved time with the doctor. Kindly assist us in keeping the doctor on time for his scheduled appointments by completing your paperwork and arriving early to register for your appointment.

We will also require a copy of your current medical insurance card(s). If you are uncertain whether or not allergy services are a covered benefit of your medical insurance contract, you should contact your insurance carrier prior to your visit to obtain this information. Our office staff can assist in providing any coding information you may require to obtain this coverage information from your insurance carrier's customer service department. It is your responsibility to be aware of any deductible, copay, co-insurance or non-covered benefit responsibilities your plan may impose on you. Please call our office in advance of your appointment to request assistance if you have financial or insurance concerns related to your scheduled appointment.

As a reminder, you should refrain from using any medication that may contain an antihistamine for at least three days prior to your visit if you are anticipating the performance of any allergy testing procedures. These types of medications interfere with our allergy skin testing procedure. If you are uncertain whether your medication contains an antihistamine you can phone our office for advice or refer to the attached list on the back of this page.

Patients with internet access should consider visiting our website at [www.nmallergy.com](http://www.nmallergy.com) for additional information about the types of conditions we treat and to access links to other informative allergy & asthma websites. We encourage you to sign up for our patient portal by providing your e-mail address at registration. Portal access will allow you to contact our office for results and communicate directly without the hassle of a phone call. Our staff will assist in training you to use this new technological option.

Our office is located at 405 North Division Road, Suite 4, in Petoskey. We are located in the medical and accounting building next to the Bear Creek Township offices. Directions are available on our website should you require assistance.

We look forward to seeing you soon. Please contact our office at 231-487-6575 should you require any additional information prior to your appointment.

Sincerely,

The Staff of Northern Michigan Allergy & Asthma Center, P.C.  
July 2016

## **ANTIHISTAMINE LIST 2016**

**Patients scheduled for an Allergy evaluation may require skin testing. The following list of medications as well as any generic equivalents or antihistamines not listed may inhibit skin test results and should be avoided at least 3 days prior to the appointment.**

Actidil, Actifed, Alavert

Allegra-60 mg, Allegra-D 12 hr. and 24 hr., Allegra-180, Allegra-30 mg, Allegra oral suspension

Astelin **nose spray** and Astepro (generic)

Atarax or Hydroxyzine

Atrohist

Benadryl

Bepreve eye drops

Bromfed

Cetirizine and Levocetirizine

Chlorpheniramine

Chlortrimeton

Claritin, Claritin-D, Claritin-24, Claritin D-24, Claritin reditabs & chewtabs, Claritin syrup

Clarinex, Clarinex-D 12 or 24 hr., Clarinex reditabs & syrup (**avoid any Clarinex 6 days prior**)

Comhist

Contac

Coricidin

Deconamine & -SR

Desloratadine

Dimetane

Dimetapp

Diphenhydramine

Doxepin

Drixoral

Dymista

Extendryl

Fexofenadine (generic Allegra)

Isoclor

Levocetirizine

Loratadine

Naldecon

Novahistine

Ornade

Optimine

Palgic 4 mg and Palgic syrup

Pataday eye drop

Patanase **nasal spray**

Pazeo eye drops

PediaCare Cough & Cold

Periactin

Phenergan

Polaramine

Poly-Histine & Polyhistamine-D

Rondec

Ru-tuss & Ru-Tuss SR

Rynatan, Rynatan-S Pediatric Suspension, Rynatan Pediatric Suspension

Rynatuss

Semprex-D

Sinequan

Sleep aids (any over-the-counter brand)

Sudafed Sins & Allergy, Sinus Nighttime, PE-Nighttime & Cold, PE Severe Cold

Tavist Trinalin Tussi-12 Tussionex

Zyrtec, Zyrtec-D, Zyrtec syrup, Zyrtec chewable tabs

Xyzal

**NORTHERN MICHIGAN ALLERGY & ASTHMA CENTER P.C. PATIENT QUESTIONNAIRE (07/2016):**

**Patient Name (include middle name):**

**Date of Birth:**

**Date:**

**Email address for secure messages/test results:**

*Please circle all symptoms you have experienced:*

sneezing	itching of throat/eyes/nose/ears	rash	no sense of smell
watery eyes	clearing of throat	headache	apnea
runny nose	shortness of breath	sinus infections	heart burn
post nasal drip	coughing	hives	restless sleep
nausea	swelling eyelids/lips/tongue/body/throat	snoring	other:
sun sensitivity	reaction to medication	trouble breathing	other:
fatigue	reaction to insect sting	latex reaction	other:
weight loss	changes in hair/nail/skin texture	nasal ulcers	
mouth ulcers	swollen, red, tender, painful joints	other:	
poor swallowing	blocked nose	sleep apnea/stop breathing during sleep	
trouble getting air IN or OUT			

*Please answer the following questions as they apply to the symptoms which you have circled above:*

When did you first notice these symptoms?

How often and when do the symptoms occur?

Is there any seasonal variation in your symptoms? If so, when are they worse?

Is there a particular time of day or night when the symptoms are worse?

Is there anything you have identified which seems to cause symptoms or make them worse?

What medications help to control your symptoms? Please list.

**Current Medications:**

Please list **any** medications you are **currently** taking (including over-the-counter medications and nasal sprays): if you filled out the attached current medication list form, you may disregard this question and refer to that list.

**Date of last use of an antihistamine medication:**

**Date of last use of allergy/asthma medications:** If you are currently using an inhaler or nebulizer treatments or have been prescribed steroids recently, please note:

**Date of last use of inhaler:** (date)

**Date of last use of nebulizer treatment:** (date)

**Date of last use of prescribed steroid medication (prednisone or others)** (date)

**Date of last use of a nasal spray:**

**Date of last use of prescribed antibiotics:**

Please list *any* allergy medications (prescription or over-the-counter) you have tried in the past that have failed to control your symptoms. List medication name and approximate date of use and the symptoms you experienced. This information is often times a requirement of your insurance company to preauthorize a newly prescribed drug for you. Adequate information in this area will assist our clinical staff in obtaining prescribed medications for you in a timely manner (turn page over if you need additional space).

Have you ever had (circle, if yes):

Hay fever    Asthma    Ear Infections    Croup    Hives    Pneumonia    Reflux  
 Bronchitis    Sinus Infections    Exercise induced wheezing    Sleep disorder/disturbance  
 Dermatitis    Celiac Disease    Eczema    Swelling attacks    Recurrent sinus infections (# of sinus infections in the last year:      )

Sensitivity to an **insect** bite/**sting**:  yes    no   Type of insect & reaction:

Have you ever had allergy testing performed?  yes    no   If yes, when?

Do you have a history of anxiety or anticipate any difficulty tolerating the skin test procedure if indicated?

Have you ever had **allergy or Xolair** (Omalizumab) shots?  yes    no   If yes, when?

Are you aware of any **foods that may cause** you to experience an **adverse reaction** or symptoms?  yes    no  
If yes, list the type of food(s) and the reaction you experience(d).

Have you ever had **adverse reactions** to any **drug**?  yes    no   If yes, list drug and the type of reaction you had.

Please list any **recently performed laboratory or xray tests** performed by another provider. List test, location or facility performed and date.

Have you ever experienced an **adverse reaction** to **latex**? If yes, explain.

#### **Past Medical History:**

Please list **any** medical conditions **you** have been diagnosed with:

#### **Surgical History:**

Please list **any** surgeries you have had:

#### **Hospitalizations:**

Please list **any** hospitalizations you have had:

#### **Emergency Room Visits:**

Please list any visits to the Emergency Room you have had:

#### **Immunizations:**

Are you up to date on your immunizations? Yes or No   Unknown

Did you ever have or when did you have your last:

Influenza (flu) shot:

Tetanus shot:

Pneumovax shot:

Shingles shot:

Tdap (Tetanus, diphtheria and pertussis) shot:

Do any members of your **family** have a **history** of allergies, asthma, immunodeficiency, cystic fibrosis?  
Mother Father Grandparent(s) Brother(s) Aunt(s) Uncle(s) Sister(s)  
Unknown family history or adopted

Please list any **other medical conditions that pertain to your close biological relatives** (parents, siblings, grandparents, aunts, uncles) as they may be relevant to your condition and please indicate the current status of your parents as noted below.

**Diseases of close biological relatives:**

**Are your parents living or deceased?**

**If living, current age of mother/father:**

**If parent(s) deceased, age at death and cause of death, if known:**

**If you are age 65 or older, do you have a living will/advance care directive or healthcare Power of Attorney to make medical decisions on your behalf if you are unable?**

**Environmental History:**

Do you live in a home or an apartment? How long have you lived there?  
Has your residence ever had water damage? yes no  
Does your house have:  
Heating: central forced air radiator gas electric wood stove HEPA or electrostatic air filters  
Air conditioning: Central window unit(s)  
Humidifier: Central separate unit(s) attic fan  
Basement: yes no If yes: musty damp seepage flooding none  
Does your bedroom have:  
Box spring mattress Allergen covers for box spring/mattress? yes no  
Carpet? yes no Plants? yes no Mini blinds? yes no  
Stuffed animals? yes no Type of pillow: feather non-feather  
Comforter: feather non-feather  
Flooring: Living area: wood tile carpet Bedroom: wood tile carpet  
Basement: wood tile carpet other:  
Circle the type of pets you have: dog cat bird horse other: none  
Does being around your pet aggravate your symptoms? yes no  
Are the pets: inside outside both Are pets allowed in bedroom?: yes no

**If patient is a child or infant:**

Is he/she in daycare?  yes  no  not applicable  
Is he/she in preschool?  yes  no  not applicable

**Custody:** If patient is a child with shared parental **custody**, describe primary and secondary living environment(s) and exposure(s) at these residences to smoke, pets, irritants or allergens:

**Smoking Status:**

Smokers in the home? yes no  
**Smoking status:** current smoker \_\_\_\_\_ packs per day \_\_\_\_\_ years daily or occasional use?  
Former smoker \_\_\_\_\_ packs per day \_\_\_\_\_ years Quit date: \_\_\_\_\_  
Never smoked  
Secondary smoke exposure: Primary home? yes no Secondary home: yes no  
Occupational exposure to second hand smoke? yes no Exposure to second hand smoke, perinatal? yes no  
Do you use chewing tobacco or other tobacco products? yes no

**Social History:**

alcohol use: no yes current past use List substance/frequency of use:  
alcohol dependence? no yes  
drug use no yes current past use List substance/frequency of use  
Marital status: Single Married Divorced Widowed Separated Child/not applicable  
Your heritage/ethnicity: American Indian Native Alaskan Asian African American  
Hawaiian/Pacific Island White Hispanic/Latino Other:

**List Hobbies:**

Please list current **occupation** (or former, if retired):

Please list any exposures in your workplace environment that seem to contribute to your symptoms.

Is there anything else that might be important for the physician to know about your condition?

*reviewed by Dr. Linehan*

## NMAAC Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. We have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a receptionist or the practice manager.

### **Do I Need a Referral?**

If you have an HMO (**Health Maintenance Organization**) plan with which we are contracted, you are required to obtain a referral authorization from your assigned primary care physician/provider **prior to** treatment. Blue Cross-Point of Service, and SOME **non-West Michigan** Blue Care Network contracts are examples of plans that have this requirement. If we have not received an authorization for your service prior to your scheduled appointment, you will be asked to reschedule or to pay for services rendered without authorization.

### **Which Plans Do You Contract With?**

We currently contract with the following **HMO's**: Blue Care Network, Priority Health-HMO and Blue Cross-Point of Service plans. **Non-HMO** companies we contract with are: ASR-Physician's Care plans, Blue Cross, Medicare, Medicare Plus Blue and Medicare Advantage, Priority Health and Priority Health Medicare, Aetna and McLaren Health Plan's Commercial PPO and Medicare Advantage plans. **We are not accepting any Medicaid plans at this time.**

### **What Is My Financial Responsibility for Services?**

Your financial responsibility depends on a variety of factors, explained in detail below. We will bill **participating** insurance companies as a courtesy to you. You are expected to pay your deductible, co-payment and co-insurance requirements as well as for non-covered services **at the time of service**. **For insurance plans that we contract with, your carrier requires that all co-pays be paid on the date of service prior to any service being rendered. If you do not have your co-pay at the time of your scheduled visit, you may be asked to reschedule your appointment. We will add a \$5.00 service fee if we have to bill you for your co-pay.** If we have not received payment from your insurance company within 45 days of service, you will be expected to pay the balance in full. You are responsible for all charges incurred for services rendered to you or your dependent(s). Patient balances that are over 90 days past due will be referred for collection and service will be terminated from this office.

**How May I Pay?** Payment is required at the time services are rendered unless other arrangements have been approved in advance. We accept payment by cash, check, money order, traveler checks, Visa, Discover, American Express and MasterCard. Payments received after the due date may incur a late charge.

### **IF YOU HAVE.....**

#### **HMO PLANS:**

Blue Care Network HMO  
Priority Health-Fully Funded HMO  
Blue Cross-Point of Service HMO

#### **YOU ARE RESPONSIBLE FOR:**

If the services you receive are covered by the plan and authorized by your assigned Primary Care Provider: All co-pays, co-insurance and deductibles are due at the time of the visit.

If the services you receive are not covered by the plan or are unauthorized by your PCP: Payment in full is collected at the time of the visit. See above for authorization requirements.

**Blue Cross:**  
(Traditional-PPO-Blue Pref)

Any applicable deductibles, co-pays or non-covered service fees are due at the time of the visit.

**Medicaid:**

**We are not accepting Medicaid plans at this time.**

**Commercial Insurance:**

Payment of the required deductible, co-pay & co-insurance charges for all services rendered at the time of the appointment for the insurances noted above as participating companies. **WE DO NOT PARTICIPATE WITH COFINITY OR UNITED HEALTHCARE or any associated networks. We do not make out of network or gap exceptions for United Healthcare.** Payment is due at the visit and we will provide an itemized receipt for you to submit for reimbursement.

**Medicare/Medicare Advantage/Medicare Plus Blue**

If you have Medicare and have not met your annual deductible we will require payment at the time of service. Any services not covered by Medicare and applicable co-pays are required at the time of the visit.

**No Insurance:** Payment in full is expected at the time of service.

**Worker's Compensation:** We can only bill your employer's compensation plan if you have provided us with an authorization for treatment from your employer and verification of compensation carrier/claim billing information **prior to** your appointment. If we are unable to verify your claim, payment in full is expected at the time of service. We will provide you with an itemized receipt to file to your employer/compensation carrier.

**LTBB Contract Health:** LTBB Contract Health with completed referral authorization and reference # prior to service only.

**Nonsufficient Funds/Returned Check Policy**

Checks returned for non-sufficient funds will be assessed a \$40.00 administrative fee. This fee must be settled before further services can be rendered. Patients who fail to respond to notices regarding NSF checks or those who issue a second non-sufficient fund check will be referred to law enforcement and will be discharged from the practice.

**Coordination of Benefits**

If you have failed to maintain current coordination of benefits information with your insurance company we will be unable to receive payment for services rendered. You are responsible for all charges denied or pended as a result of your failure to comply with your insurance companies request for information.

**Failed Appointment Policy**

Missed appointments represent a cost to us and to other patients who could have been cared for during the time set aside for you. We request the courtesy of a 24-hour notice for cancellation of an appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

**What if My Child Needs to See the Physician?**

A parent or legal guardian must accompany patients who are minors to all patient encounters. The accompanying individual is responsible for payment of charges at the time of service. We are unable to bill third parties for payment of non-covered services, co-pays and deductibles. We will provide an itemized receipt of payment to the accompanying responsible adult so that he/she may seek reimbursement for their payment from the legally designated financially responsible party.

**Late Payments**

Patients with an outstanding balance on account must make arrangements for payment prior to scheduling appointments. Failure to respond to payment notices or to make prearranged payments on account will result in referral of delinquent accounts to a credit reporting collection agency and termination of availability of our services to you. All delinquent accounts over 90 days past due will result in collection and discharge from the practice without exception. Late payments may incur an interest charge.

I have read and understand the terms of the financial policy and agree to abide by the terms set forth.

Signed \_\_\_\_\_

Date \_\_\_\_\_



## Electronic Prescribing

Northern Michigan Allergy & Asthma Center, P.C. will begin electronic prescription of all patient **medications effective 07-20-2009**. **We will no longer give you a written prescription for medications** prescribed for you. Any new medications prescribed or refills authorized will be sent directly from our computer system to the pharmacy of your choice. This will eliminate the need for you to hand carry a prescription to your pharmacy and should expedite dispensing your medications to you. You simply need to pick up the prescription from your local pharmacy or await its arrival if you chose a mail order option.

Please provide us with the name of your preferred pharmacy for prescription requests. If you use a combination of local and mail order service, you will need to designate on this form in what instance you would like those options used. If you have specific requests, you will need to let us know prior to being prescribed a medication. It is your responsibility to keep us informed of any changes to your preference(s) or insurance plan requirements. We will use the information provided on this form as the default pharmacy choice for future prescriptions unless you inform us otherwise.

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred **LOCAL** pharmacy to keep on file for all prescriptions you intend to pick up locally:

Name of Pharmacy: \_\_\_\_\_

City, State \_\_\_\_\_ Phone: \_\_\_\_\_

- Prescribe all of my medications to this local pharmacy
- Prescribe only certain medications to the local pharmacy. Specify in what instance we should use this option.

Preferred **MAIL ORDER** pharmacy to keep on file for all prescriptions you intend to mail order

Name of Pharmacy: \_\_\_\_\_

City, State \_\_\_\_\_ Phone: \_\_\_\_\_

- Prescribe all of my medications to this mail order pharmacy. Please indicate if you can receive your medications in a multiple month supply.
- 30 day supply       60 day supply       90 day supply
- Prescribe only certain medications to the mail order pharmacy. Specify in what instance we should use this option.

### **PRESCRIPTION REFILL REQUESTS**

When you are in need of prescription refills, **ALL** requests for refills should be directed to the pharmacy of your choice. Contact your pharmacy and they will contact our office for approval for your medication request.



# **NMAAC REGISTRATION FORM**

Date: \_\_\_\_\_

## **PATIENT INFORMATION**

Patient Name (include middle initial): \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Seasonal Address (if applicable): \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Cell phone: ( ) \_\_\_\_\_  
Seasonal Phone: ( ) \_\_\_\_\_ Gender:  Male  Female  
Date of Birth: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed  Separated  
Patient Employed by \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ E-MAIL address: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact Phone: ( ) \_\_\_\_\_ and Cell Phone: ( ) \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_  
Your heritage/ethnicity:  American Indian  Native Alaskan  Asian  African American  
 Hawaiian/Pacific Island  White  Hispanic/Latino  Other:  
Preferred number to contact you with test results: \_\_\_\_\_  
Email address for secure messaging and test results: \_\_\_\_\_

## **PRIMARY INSURANCE INFORMATION**

Name of Primary Insurance: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Policyholder/Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Policyholder's Employer: \_\_\_\_\_  
Relationship of patient to policyholder:  self  spouse  child  stepchild  other dependent  
Address of Policyholder/Subscriber (if different from patient): \_\_\_\_\_

## **ADDITIONAL INSURANCE**

Is patient covered by another insurance policy?  yes  no  
Name of other insurance \_\_\_\_\_ Policy#: \_\_\_\_\_  
Group # \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_  
Policyholders Date of Birth: \_\_\_\_\_ Relation to Patient:  self  spouse  child  stepchild  other

## **ASSIGNMENT AND RELEASE**

I, the undersigned certify that I or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Linehan/NMAAC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/NMAAC to release all information necessary to secure the payment of benefits. I authorize the use of his signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

