Berkshire Allergy & Asthma Center
2210 Ridgewood Road, Suite 100
Wyomissing, PA 19610
(610) 372-0502

It is with pleasure that we welcome you as a new patient to Berkshire Allergy & Asthma Center. Dr. Hein is a specialist, who is board certified in the diagnosis and treatment of allergy, asthma, and immunology.

Asthma and allergic reactions are among the leading causes of ER visits and hospitalizations every year. Statistically, patients under the care of an allergy/asthma specialist experience fewer emergency care or sick care visits. They also report fewer missed work/school days, which increases overall productivity.

Enclosed you will find a patient registration form, billing policy, allergy questionnaire and previous medication list. Please complete all forms as accurately as possible and bring them with you to your initial visit.

We have reserved two hours for your new patient evaluation, which generally includes a comprehensive health history, physical examination, allergy skin testing, spirometry (if applicable) and extensive patient education. Please allow sufficient time in your schedule to allow us to complete this work-up. If you have had allergy skin testing done in the past five years, it would be helpful to obtain a copy of these results and bring them to your appointment.

Certain medications may interfere with allergy testing. Antihistamines, such as over-the-counter (Benadryl, Alavert, Claritin, Zyrtec, and Allegra) and prescription (Clarinex and Xyzal) must be discontinued for three days prior to the appointment in order to obtain accurate skin testing results. If you are unsure of any medication you are taking and its possible interference with skin testing, please contact our office. We also request that you bring a list of your current medications. If stopping asthma or hive medications will make you worse, please continue using them.

If you are unable to keep your appointment as scheduled, please notify our office as soon as possible. In order to avoid any no show or late cancellation charges, we require 24 hours notice for cancellations. See Billing Policy regarding these charges.

We look forward to meeting you and providing your allergy/asthma needs. Please do not hesitate to contact our office at (610) 372-0502 with any questions.

Directions to our office:

From Wal Mart in Wyomissing: Take State Hill Road to Berkshire Boulevard (this is the road that runs Wal Mart between Wal Mart and Starbucks). Turn left directly behind Wal Mart onto Ridgewood Road. Take the 2nd right into the Berkshire Place complex (directly across the street from BTI - Berks Technical Institute.) Pull up the drive and turn left. Our office is located straight ahead in the back of the parking lot.

From the Crown Plaza: Take Papermill Road to the Crown Plaza. Turn left at the traffic light on Berkshire Boulevard. Turn right at the next light onto Ridgewood Road. Take the 3rd left turn into the Berkshire Place complex. Pull up the drive and turn left. Our office is located straight ahead in the back of the parking lot.

Patient Information

Patient's Name: _____ Date of Birth: _____ Sex: M F

Race: _____ Ethnicity: _____ Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Primary Care Physician: _____ Social Security #: _____

EMPLOYMENT INFORMATION

Employer: _____ Work Phone #: _____

Employer's Address: _____

Spouse's Name (if applicable): _____

Spouse's Date of Birth: _____ Social Security #: _____

Spouse's Employer: _____

Work #: _____ Cell Phone #: _____

Insurance Information

Company # 1: _____ ID/Policy #: _____

Group #: _____

Company # 2: _____ ID/Policy #: _____

Group #: _____

I request that payment of authorized benefits be made on my behalf to BERKSHIRE ALLERGY & ASTHMA CENTER, INC. for any services furnished to me by these providers. I authorize these providers to release any pertinent medication information to my insurance company for the determination of these benefits and I understand that I am financially responsible for any non-covered services.

Patient's Signature: _____ Date: _____

EMERGENCY CONTACT PERSON OTHER THAN ABOVE:

Name: _____ Phone: _____

Address: _____

Relationship to patient: _____

INTEGRATED MEDICAL GROUP, PC
Billing Policy

This financial policy contains important information about billing and payment for our professional services. Please read this entire policy in order to prevent any misunderstandings concerning the financial aspects of your medical services.

Payment is due at the time of service unless prior arrangements have been made.

If you have health insurance, you are responsible for presenting your current insurance card at the time of every service.

If IMG participates with your insurance, we will file your claim and accept their approved reimbursement as payment in full for covered services. If IMG does NOT participate with your insurance, we will still file a claim with your insurance company as a courtesy to our patients. All deductibles, co-payments, co-insurance and non-covered services are your responsibility to pay.
Please remember: Your insurance is a contract between you and your insurance company. We are not at party to that contract.

Payment can be made by cash, check, money order and credit or debit card. We accept Visa, MasterCard and Discover Card.
If your check is returned for insufficient funds, you will be charged a returned check fee of $30.

If you request the completion of medical forms, you may be charged a fee of $15.

If your insurance requires any referrals or authorizations, it is your responsibility to provide them prior to your visit. In the absence of a required authorization or referral, you may be rescheduled or personally responsible for payment.

A late charge of 1.5% per month or maximum allowable rate may be added for balances over 30 days old.

If your personal balance is not paid within 90 days, your account may be turned over to a collection agency. In that case, you will be responsible for any and all collection agency fees.

I have read all the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. In the event my insurance company is billed, I authorized payment of medical benefits to be paid directly to INTEGRATED MEDICAL GROUP. A photocopy of this agreement shall be considered effective and valid as original. I understand that any services or procedures not covered by my insurance are my responsibility.

Print patient's Name: _____

Print parent/guardian name: _____

Signature: _____ **Date:**_____

ALLERGY QUESTIONNAIRE

Patients Name: _____ DOB: _____

In preparation for your upcoming visit, please take a few minutes to fill out the survey below. This will help us better direct your care. Thank you.

Please list your current health problems: _____

_____

_____

Please list your current medications: _____

_____

_____

Airway Triggers: Pets – Y / N Harsh odors – Y / N Grass cutting – Y / N Weather changes – Y / N

Any Infections? Sinus – Y / N Ear – Y / N Chest – Y / N

Past Medical History, Please list any prior surgeries & fractures along with dates: _____

_____

_____

Do you have any pets? If yes, please specify: _____ Are there smokers in the home? _____

Are there feather products in the home? _____

What type of heat do you have? Forced hot air, Radiator, Wood Stove, Coal Stove, other: _____

Do you have a Humidifier? _____ Do you have a Dehumidifier? _____

Do you have an air cleaner? _____

Do you have any medication allergies? If yes, please specify: _____

_____

_____

_____

Do you have any food allergies? If you do, please specify: _____

_____

_____

What is your occupation? _____

Do you now or have you ever smoked? _____ How much alcohol do you consume on a weekly basis? _____

DO NOT TAKE ANY ANTIHISTAMINES FOR 3 DAYS PRIOR TO YOUR APPOINTMENT!

Patient/Parent/Guardian Signature: _____ Date: _____

MEDICATION HISTORY

Due to the recent availability of generic alternative for oral antihistamines, nasal steroid sprays, and reflux medications, insurance companies are reevaluating patient's prescriptions despite current/past use or prior insurance coverage of these medications.

It is becoming increasingly difficult to get prescriptions covered for our patients because of insurance formulary guidelines. Please complete the following information to help expedite this process.

Failure to complete this form may result in non-coverage for your prescriptions. Your cooperation is greatly appreciated.

Has the patient ever tried the following medications? Please state the estimated date, year tried, how it worked, and side effects.

Antihistamine / Decongestant:

Benadryl _____

Sudafed _____

Claritin/Alavert/Loratadine _____

Claritin D _____

Xyzal (Levocetirizine) _____

Allegra (Fexofenadine) _____

Allegra D _____

Zyrtec _____

Zyrtec D _____

Reflux / Heartburn:

Pepcid (Famotidine) _____

Zantac (Ranitidine) _____

Prilosec (Omeprazole) _____

Tagamet (Cimetidine) _____

Prevacid _____

Nexium _____

Protonix _____

Aciphex _____

Nasal Sprays:

Flonase (Fluticasone) _____

Nasacort AQ/Triamcinolone _____

Nasalide/Nasarel (Flunisolide) _____

Nasonex _____

Omnaris _____

Rhinocort AQ/Budesonide _____

Veramyst _____

Astelin / Astepro/Azelastine _____

Patanase / Olopatadine _____

Asthma Medications:

Singulair _____

Albuterol MDI _____

ProAir HFA _____

Proventil HFA _____

Ventolin HFA _____

Breo _____

Advair Diskus 100 / 250 / 500 _____

Advair HFA 45 / 115 / 230 _____

Dulera 100 / 200 _____

Symbicort 80 / 160 _____

Asmanex _____

Flovent / Arnuity _____

Pulmicort _____

Qvar _____

Patient name/DOB_____