

TLC Allergy & Asthma Associates, Inc.

OTTO LIAO, MD

American Board of Internal Medicine
American Board of Pediatrics
American Board of Allergy and Immunology

Practice Limited to Allergy

Tel: (714) 838-2617 or (949) 452-3730

Date: ____/____/____

Dear _____,

This is to confirm your appointment on ____/____/____ at ____:____ at our office in:

1101 E. Bryan Ave.
Suite B
Tustin, CA 92780

25401 Cabot Rd.
Suite 101
Laguna Hills, CA 92653

18800 Main St.
Suite 107
Huntington Bch, CA 92648

800 Corporate Dr.
Suite 100
Ladera Ranch, CA 92694

Please take a moment to complete the enclosed medical and personal information sheets, making sure to fill out **both front and back**. This will greatly enhance our ability to have quality time together in the office. Please bring these forms, along with an insurance identification card at the time of your first visit.

During your first appointment, a medical history and pertinent physical examination will be done. This may take up to **one hour**, so please allow sufficient time. Ordinarily, no allergy testing is done at the first visit. If allergy testing is required, the appropriate appointments will be made at the conclusion of your initial consultation.

Many of our patients are very sensitive to perfumes, strong odors, and foods. Therefore, please refrain from using fragrances on the day of your visit and do not bring any food items into the office waiting room.

Appointment schedules are generally closely followed. You will find that we are concerned with your time as well as ours. We look forward to seeing you. If you are unable to keep your scheduled appointment for any reason, it is important to notify us at least 24 hours prior to your appointment. There is a **\$35 fee** for any missed appointments if our office is not notified. For more office information you may see our website at: **www.TLCAllergy.com** or call the phone numbers above.

Sincerely,

Otto Liao, MD

PATIENT INFORMATION

Last Name:	Age:	Date of Birth:
First Name:	Gender: M F	Driver's License:
Address:		Social Security #:
City, State, Zip:		Home Phone:
Employer:	Work Phone:	Cell Phone:
Employer Address:		Email:

RESPONSIBLE PARTY

Same as above? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Relationship to Guarantor: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Last Name:	Gender: M F Marital Status: S M D W
First Name:	Date of Birth:
Address:	Driver's License:
City, State, Zip:	Social Security #:
Employer:	Work Phone:
Employer Address:	Home Phone:
	Cell Phone/Email:

INSURANCE INFORMATION

Primary Insurance:	Policy/Subscriber:
Address:	Insured Policy ID:
City, State, Zip:	Group Number:
Plan Phone:	Date of Birth:
Effective Dates:	Patient Relationship to Subscriber:
Secondary Insurance:	Policy Subscriber:
Address:	Insured Policy ID:
City, State, Zip:	Group Number:
Plan Phone:	Date of Birth:
Effective Dates:	Patient Relationship to Subscriber:

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/Legal Guardian Name:	Emergency Contact:
Address(if different than patient):	Address(if different than patient):
	Patient relationship to Contact:
Parent Home/Work Phone:	Contact Home/Work Phone:

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

The undersigned agrees, whether he signs as agent or as a patient, that in consideration of services to be rendered (e.g. skin testing, office visit etc.) by TLC Allergy and Asthma Associates, Inc., to the patient named above, he hereby obligates himself, assumes financial responsibility, and agrees to pay upon request to provider all charges for such services incurred by said patient. Should the account be referred to an attorney/collection agency for collection, the undersigned shall pay all responsible attorney fees and collection expenses. The undersigned understands that all bills are payable upon presentation and that she/he, not the insurance company, is responsible for the payment of the services. This office will file and collect from Insurance when insurance benefits are present. I hereby authorize TLC Allergy and Asthma Associates, Inc. to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered on above patient.

X _____ Date: _____
Signature

TLC Allergy & Asthma Associates, Inc.

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Notice Regarding Privacy of Personal Health Information

May we leave a message on your **voice mail** at (home, work, or cell) regarding:

- Normal lab results? Yes No
- Your appointments? Yes No
- Your insurance or billing? Yes No

Please name any other people with whom we may discuss or leave messages with regarding appointment, lab, or billing. If you do not wish to have information left with anyone but yourself, please check the box.

None. Do not leave information with anyone else.

_____ relationship _____

_____ relationship _____

Should you wish to cancel any of the above authorizations in the future, you must notify this office in writing. Thank you.

Signature of responsible party: _____ Date _____

Print name: _____

TLC Allergy & Asthma Associates, Inc.
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NOTICE OF PRIVACY PRACTICES

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

YOUR RIGHTS AND YOUR HEALTH INFORMATION

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to TLC Allergy and Asthma Associates, Inc. 1101 E. Bryan, Ste B, Tustin, CA 92780 (or fax 714-838-2640).
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to TLC Allergy and Asthma Associates, Inc. 1101 E. Bryan, Ste B, Tustin, CA 92780 (or fax 714-838-2640). You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact TLC Allergy and Asthma Associates, Inc. 1101 E. Bryan, Ste B, Tustin, CA 92780 (or fax 714-838-2640).
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact TLC Allergy and Asthma Associates, Inc. 1101 E. Bryan, Ste B, Tustin, CA 92780 (or fax 714-838-2640). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

PATIENT/GUARANTOR AGREEMENT

1. On my own behalf and on behalf of my spouse and minor children, including stepchildren, I hereby authorize treatment by TLC Allergy and Asthma Associates, Inc.
2. I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due TLC Allergy and Asthma Associates, Inc agree to pay all cost of collections including collection agency fees. I understand there is a \$25.00 returned check fee should a check be returned for any reason.
3. I hereby authorize the release of any and all medical and/or charge information as is necessary for third-party reimbursement from Medicare, Blue Shield and/or any other agency involved in the payment of my treatment.
4. I also direct and assign payment from said third parties to TLC Allergy and Asthma Associates, Inc. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to TLC Allergy and Asthma Associates, Inc for any charges not covered by insurance. If payment from my insurance is not received within 120 days, my account will become due and payable by me. Any balance remaining on the account after insurance pays will be due payable by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. Charges not payable by my insurance carrier are due immediately.
5. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or body fluids. In the event of such direct exposure, State laws require a sample of my blood to be tested for the presence of infectious diseases. The results of these tests will be released to me and my family and to the healthcare workers who suffered exposure.
6. The assignment/obligations and authorizations set forth in this statement and the insurance assignment shall be binding upon me both for the present treatment and that which may be rendered to me and my family in the future by TLC Allergy and Asthma Associates, Inc.
7. I authorize a copy of my TLC Allergy and Asthma Associates, Inc medical record to be forwarded to my Primary Care Physician as well as any and all attending or consulting practitioners.

I hereby authorize direct payment to Dr. Otto Liao or TLC Allergy and Asthma Associates, Inc of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the doctor and/or any service supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

REFERRAL RESPONSIBILITY

This is to advise you that it is your responsibility, as a patient, to obtain a referral from your primary Care Physician for services rendered. This referral must be dated prior to the time of service. It is also your responsibility to keep track and make a copy of your referrals to be sure that the visits or length of time of the referrals do not run out. If a referral is not obtained, you will be responsible for the payment to the doctor.

I, _____ (the patient or representative), acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Signature of Patient or Responsible Party: _____

Name of Patient: _____

Date: _____

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FINANCIAL POLICY

Our office files primary insurance as a courtesy for all of our patients. **Please bring your insurance card with you and keep our office informed of all insurance changes and special authorization requests.** Payment is expected at the time of service by cash or check. Patients are responsible for the appropriate deductible and co-insurance. For members of health plans in which we participate, the appropriate deductible, co-pay, or patient's portion will be collected. Your insurance is a contract between you and your insurance company. **You are responsible** for all bills regardless of the type of insurance coverage you may have. Please contact your insurance company to verify coverage for our services. **We allow 120 days for your insurance carrier to pay. After that time the unpaid balance is due to payable by you.**

You are expected to pay all charges in full at the time of service if:

1. You have no insurance coverage.
2. You prefer to file your own insurance.
3. Your insurance carrier sends payment directly to you.
4. Insurance benefits cannot be verified by our office.
5. Proper authorization/referral has not been received.

DELINQUENT ACCOUNTS

1. Accounts past due will be placed on a COD status at which time all charges must be paid in full at each visit until account is brought current.
2. **Accounts past due are subject to collection.** All fees including, but not limited to collection fees, attorney fees and court fees incurred shall become your responsibility in addition to the balance due this office.

RETURNED CHECKS

There is a \$25.00 service fee on all returned checks. Returned checks must be redeemed with certified funds (cashier's check, money order, cash).

FAILED APPOINTMENTS

There is a **\$35.00 service fee** for failed appointments that are not cancelled or rescheduled at least 24 hours in advance of your scheduled office visit.

MINOR PATIENTS

We require that a minor patient be accompanied by an adult (parent or legal guardian). The adult accompanying the minor patient is required to pay in accordance with our policies. We do not accept third party assignments nor do we recognize or enforce the terms of divorce decrees.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY THE TERMS OF THIS POLICY.

PATIENT NAME (please print)

SIGNATURE (Responsible Party)

DATE

Rev (5/09)

To be completed by patient or parent.

Describe in your own words the reason for this visit:

Nasal/Throat Symptoms

- nasal congestion
- nasal discharge- clear, yellow, green
- post nasal drip/throat irritation
- hoarseness/change of voice
- throat tightening/difficulty swallowing
- nasal itchiness
- frequent nose blowing
- sneezing
- loss of smell/taste

Chest Symptoms

- cough
- wheezing
- shortness of breath
- chest tightness
- waking up at night
- phlem/sputum
- difficulty with exercise
- used an inhaler medicine in the past
- severe episodes in last year
- emergency room visits
- hospitalizations

WHAT MAKES YOUR SYMPTOMS WORSE?

- | | | | |
|--------------------------------------------------------|-------------------------------------------------|---------------------------------------------|---------------------------------------|
| <input type="checkbox"/> pollens (grass, weeds, trees) | <input type="checkbox"/> viral infections/colds | <input type="checkbox"/> dust | <input type="checkbox"/> latex |
| <input type="checkbox"/> animals (cat, dog, horse) | <input type="checkbox"/> mold/mildew | <input type="checkbox"/> exercise | <input type="checkbox"/> smoke |
| <input type="checkbox"/> weather changes | <input type="checkbox"/> Santa Ana winds | <input type="checkbox"/> stress | <input type="checkbox"/> strong odors |
| <input type="checkbox"/> emotions/laughter/crying | <input type="checkbox"/> cold air/humidity | <input type="checkbox"/> perfumes/chemicals | |

WHICH SEASONS DO YOU HAVE SYMPTOMS?

- SPRING SUMMER FALL WINTER YEAR-ROUND

Name: _____

Date _____

Sinus Symptoms

- frequent sinus infections
- facial pain/pressure/congestion
- tooth pain
- headaches
- bad breath

Eye Symptoms

- itchiness, redness, puffiness
- watery discharge
- eyelid irritation
- dark circles under eyes

Ear Symptoms

- frequent ear infections/fluid
- itching/popping/pain
- ringing/decreased hearing

Skin symptoms

- itchiness
- hives
- eczema/rash
- areas of swelling

Current Medications: Please list all medications that you are currently taking, including over-the-counter medications (**attach additional sheet if necessary**).

	<u>Medication</u>	<u>Prescribed By</u>	<u>Date Started</u>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Previous Medications: Please list any therapies previously tried for your problem.

	<u>Medication</u>	<u>Date Stopped</u>	<u>Reason For Stopping</u>
1.			
2.			
3.			
4.			
5.			

Please list all hospitalizations (including year and reason)

- 1.
- 2.
- 3.

Medical History:

1. Have you ever had nasal or sinus surgery? No Yes date _____

2. Have you had a tonsillectomy or adenoidectomy? No Yes date _____

3. Have you had ear tubes? No Yes date _____

4. Have you ever been tested for allergies? No Yes date _____

If so, did you have skin tests or blood tests? Skin Blood

5. Have you ever had allergy injections? No Yes

If so, please give dates and location: _____

Did they help? No Yes

6. Any chest x-rays/sinus x-rays/CT scans? No Yes date _____

Results: Normal Abnormal _____

7. List all known drug allergies: _____

8. List all known food allergies: _____

9. Have you ever had an allergic reaction to bee strings, latex or aspirin? No Yes

Describe: _____

Name: _____

Date _____

Check any previous or current medical conditions that you may have below.

- | | | |
|--------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Eye Diseases (Glaucoma) | <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Arthritis/Joint pains | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Seizures/Blackouts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Myocardial Infarct/Heart Attack/Heart Surgery | |
| <input type="checkbox"/> Other: _____ | | |

For children younger than 15 years old, complete the following:

1. Birth Weight: _____ Full term Premature _____
2. Were there any complications following delivery? Yes No
Explain: _____
3. Has growth and development been normal? Yes No
Explain: _____
4. Are immunizations up to date? Yes No
5. Does your child attend daycare or preschool? Yes No
Age started _____

Family History

		NASAL		SKIN	
	AGES	ASTHMA	ALLERGIES	ALLERGY	OTHER
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Brothers	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Sisters	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Children	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

Name: _____

Date _____

Social History

Current Occupation: _____

Marital Status: **S M D W**

Education: Grade in school: _____ College Post-grad

Hobbies/sports: _____

Smoking History: Never Previous Current _____ packs/day for _____ yrs

Environmental History: (Please check the appropriate boxes.)

Home: House Apartment Condo Dormitory

How long have you been living there: _____ #Bedrooms _____ #People: _____

Pets: Cat Dog Birds Hamster Rabbit Horses Other: _____

Smokers: None Indoors By: _____ Outdoors By: _____

Heat: Central Radiator

Air conditioning: Central Window

Pillows/blankets: Feather Non-feather Bed: Mattress Waterbed

Flooring: Hardwood Carpet Tile Other: _____

Evidence of mold/water damage: No Yes

Current physicians seen:

<u>Name</u>	<u>Specialty</u>	<u>Date Last Seen</u>
1.	Primary care physician	
2.		
3.		
4.		
5.		

Whom may we thank for referring you?

Physician Office Name: _____

Relative or Friend Name: _____

Insurance Provider Directory

Advertisement

Website

Other: _____

Name: _____

Date _____