ALLERGY & ASTHMA ASSOCIATES, S.C.

Dr. Daniel Wendelborn, M.D.
Dr. Karen Konz, D.O.
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Phone | 920.739.5213 FAX | 920.739.1444
www.foxcitiesallergists.com

Patient information: Allergy skin testing (The Basics)

What is allergy skin testing?

Allergy skin testing is testing that helps your doctor figure out what you are allergic to. Doctors use 2 main types of allergy skin tests. The most common is called a skin prick test. The doctor puts a drop of the substance you might be allergic to on your skin by making a tiny prick using a sterile applicator. He or she then watches your skin to see if the skin around the prick turns red and bumpy. If that happens, it usually means you are allergic to the substance.

If your skin does NOT turn red and bumpy, your doctor might still think you could be allergic to the substance. If that happens, he or she might inject a tiny amount of the substance under your skin. This is called an "intradermal" test. Intradermal tests are slightly better at showing an allergy because more of the test substance gets into the skin. Because this is a stronger type of test, it can sometimes cause allergic reactions, and it is not done for some types of allergies, such as food allergies.

Why do I need allergy skin testing?

Your doctor might recommend allergy skin testing if you have symptoms that seem to be caused by an allergy.

If you know exactly what is causing your allergies, you can avoid the substances and choose the best treatment.

What happens during skin allergy testing?

Your doctor might tell you to stop taking certain medicines (such as allergy medicines) for up to 3-7 days week before you get an allergy skin test.

The pricks or injections are done on the upper part of your back and sometimes on your arms. This is not painful, but small children might find it upsetting. You might get tested for a few different substances at the same time.

If you are allergic to any of the substances, itchy red bumps usually show up in 15 to 20 minutes. The bumps go away within an hour or so.

After reading and recording the potential allergies, your doctor or nurse will wash off any remaining test solution and may apply an anti-itch cream. You can then go about your day.

PLEASE PRINT CLEARLY

Today's Date_____

Adult Patient Information

PATIENT: Last Name	First Name	Middle Initial	Nickname	Sex
Street Address	P.O. Box (if applicable)	City		Zip
Social Security No.	Date of Birth	Home Phone		Marital Status: (circle) S M D W
Work Phone/Cell Phone	Employer			
Email Address *To be used only for appointment reminders and medically related information. Your information will be kept strictly confidential and will not be given to any third party.				
Primary Care Physician	Address			
Other immediate family members seen in our office:				
SPOUSE: Last Name	First Name	Middle Initial	Social Security No.	
Date of Birth	Work Phone/Cell Phone	Employer		
Please indicate who bills should be addressed to:				
CONTACT INFORMATION (Please list a relative or friend **NOT** living with the patient who could provide forwarding information if needed):				
Last Name	First Name	Relationship to Patient		
Address		Home Phone		

Insurance Information **You will need to present insurance card(s) at the time of the patient's visit**

Please list your insurance(s) in the correct order of coverage. If complete insurance information is not provided, all bills will be sent to the responsible party.

PRIMARY INSURANCE COMPANY:			
Claims Address			
Subscriber #	Effective Date	Group Name	Group #
Subscriber's Name	Employer		
SECONDARY INSURANCE COMPANY:			
Claims Address			
Subscriber #	Effective Date	Group Name	Group #
Subscriber's Name	Employer		

MEDICARE PATIENTS ONLY:

Patient Signature on File for Medicare Claims

I request that payment of authorized Medicare benefits be made payable on my behalf to Allergy and Asthma Associates, SC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. *This authorization is in effect until I choose to revoke it.*

X _____

Beneficiary Signature Date

Referral Source Whom may we thank for this referral?

- ☐ **Physician (Name):** _____ **Address:** _____
- ☐ Friend or Family (Name): _____
- ☐ Advertisement in _____
- ☐ Internet Site: _____
- ☐ Other: _____
- ☐ Insurance Provider Network

The above information is true to the best of my knowledge.

X _____

Patient Signature Date

For office use only: Initial	Date of entry

Allergy and Asthma Associates, S.C.

Daniel F. Wendelborn, M.D. ◆ Karen R. Konz, D.O.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Allergy and Asthma Associates, S.C.'s Notice of Privacy Practices (attached). This Notice describes how Allergy and Asthma Associates, S.C. may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

AUTHORIZATION TO RELEASE AND ASSIGN INSURANCE BENEFITS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Allergy and Asthma Associates, S.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and lab's expenses.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

IDENTITY THEFT PREVENTION PROGRAM

Effective 5-1-09 the Federal Trade Commission issued regulations which require clinics to implement a written identity theft prevention program (Red Flag Rule) as part of the Fair and Accurate Credit Transactions Act. In order to protect an individual's health information from compromise and misuse we are required to obtain a form of photo ID.

Patient name: _____
(Please print)

Patient Signature: _____ Date: _____
(If over 18, sign above)

Minor Child:
Parent/Guardian Signature: _____

Relationship to patient: _____

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PATIENT INSTRUCTION/CONSENT SHEET FOR ALLERGY SKIN TESTING

Skin Test: Skin tests are a method of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, or swelling, or flare in the surrounding area of redness). The results are read 15 to 20 minutes after application of the allergen. The skin test methods used are:

Prick Method: The skin is scratched or pricked where a drop of allergen has already been placed.

Intradermal Method: This method consists of injecting small amounts of an allergen into the superficial layers of the skin.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergenic antibodies and are not necessarily correlated with clinical symptoms.

You will be skin tested to important midwestern airborne allergens and possibly some foods. These include trees, grasses, weeds, molds, dust mites, and danders and, if needed, foods. The skin testing generally takes 2 hours. Prick tests will be performed on your back and intradermal tests on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised itchy hive (caused by histamine release into the skin) will appear on your skin within 15-20 minutes. These positive reactions will gradually disappear over a period of 30-60 minutes, and, typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit. You may be scheduled for skin testing to antibiotics, caines, venoms, or other biological agents. The same guidelines apply.

DO NOT...

1. No prescription or over-the-counter antihistamines should be used at least 3 days prior to the scheduled skin testing. These include cold tablets, sinus tablets, hay fever medications, over-the-counter sleeping medicines (e.g., Nytol) or oral treatments for itchy skin. Some of the names of these drugs include Actifed, Drixoral, Dimetapp, Dristan, Ornade, Benadryl, Rondec, Trinalin, Zyrtec, Claritin, Allegra, and many others. If you have any questions whether or not you are using an antihistamine, please ask the nurse or the doctor. Patients on Hismanal should not take this antihistamine for 6 weeks prior to skin tests.

2. Do not stop taking your asthma medication prior to testing.

YOU MAY...

1. You may continue on your intranasal allergy sprays such as Nasacort, Rhinocort, Vancenase, or Nasalide.

- more -

2. Asthma inhalers (Intal, beclomethasone [Beclovent, Vanceril], Aerobid, Atrovent, Azmacort, Alupent, Brethaire, Albuterol [Proventil, Ventolin]) and oral theophylline (Theo-Dur, T-Phyl, Uniphyl, Theo-24, etc.) do not interfere with skin testing and should be used as prescribed.

3. Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking.

Please let the physician and nurse know:

1. If you are taking any beta-blockers or antidepressants.

2. If you are pregnant.

3. If you have a fever or wheezing.

4. Any medications you are taking (bring a list if necessary).

Skin testing will be administered at this medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. *PLEASE NOTE THAT THESE REACTIONS RARELY OCCUR BUT IN THE EVENT A REACTION WOULD OCCUR, THE STAFF IS FULLY TRAINED AND EMERGENCY EQUIPMENT IS AVAILABLE.*

The time set aside for your skin test is exclusively yours for which special antigens are prepared. If for any reason you need to change your skin test appointment, please give us at least 24 hours notice.

I have read the patient information sheet on allergy skin testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

PATIENT NAME (Print)_____

PATIENT SIGNATURE_____ DATE SIGNED_____
(Or parent if patient is a minor)

_____ **I give my permission to Allergy and Asthma Associates, S.C. to leave a detailed message regarding**
Intl **lab results or other medical information on my answering machine if I am not available.**

Allergy and Asthma Associates, SC
FINANCIAL POLICY

Please read and initial next to each of the policies below, sign and date at the bottom.

_____ **Insurance:**
As a courtesy to you, Allergy and Asthma Associates will handle all claim submissions to primary and secondary insurance carriers. However, you must provide us with **current** copies of your insurance card(s) and notify us **immediately** when there are any changes in this information. Wisconsin law dictates that health insurance carriers must process claims within 90 days of submission. If your carrier has not paid your claim within 90 days, you will be responsible for payment.

Any questions regarding your coverage, eligibility and benefits (payment) must be communicated by you directly with your insurance carrier, as you hold the contract with that company. Please note: The insured is responsible for payment on any claims that are 1) applied to deductible or co-insurance; 2) denied; 3) partially paid, 4) partially paid specifically due to the carrier's arbitrary determination of usual and customary rates.

_____ **Referrals:**
If your insurance company requires a referral for your visit, you are responsible for making that determination and making sure that referral is completed by the time of service. If this is not done, you may be personally responsible for the services rendered.

_____ **No Insurance (Self Pay):**
Effective 5/1/2014 anyone without medical insurance can receive a 10% discount if the balance is paid in full at the time of the appointment. Otherwise, call the billing office after receiving your statement to set up a payment plan.

_____ **Workers Compensation and Disability:**
Workers Compensation claims will be submitted on your behalf, as long as complete and accurate information is provided to our office. Claims that are denied or disputed are the responsibility of the insured and our credit terms will then apply. Any claim not paid within 60 days will be your responsibility.

_____ **Copays:**
Office visit copays are due at time of service. We accept cash, checks, Visa, MasterCard, American Express and Discover.

_____ **Cancellation and Missed Appointments:**
Appointments are an important commitment of reserved time for you and the physician/practice. Missed appointments create interruption for staff members and other patients on the schedule. We understand that situations do arise in which you must cancel your appointment; therefore we require that you call at least 24 hours in advance.

To cancel an appointment, please call 920-739-5213. If you do not reach the receptionist, you may leave a detailed message on our voicemail.

A "no show" is someone who misses an appointment without canceling 24 hours in advance, or who fails to show up for a scheduled appointment.

- First missed appointment: We will contact you and offer to reschedule your appointment. You will also receive a letter reminding you of our policy.
- Any additional missed appointments: A $25.00 fee will be billed to your account. Your insurance company will not be billed for fees associated with missed appointments. Missed appointment fees will be the sole responsibility of the patient and must be paid in full before the patient's next appointment. Patients with three or more missed appointments in a twelve month period may be dismissed from the practice.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with staff approval.

_____ **Payment Plans:**
The average cost of the initial evaluation and testing is approximately $700-$2,000. Our billing staff is more than willing to establish a payment plan that will accommodate your budget.

_____ **Returned Checks:**
There will be a $35.00 service fee charged to your account for any NSF checks.

I have read the Financial Policy and understand its content. I agree to the terms of the Policy.

_____ _____ _____

Signature of Patient or Responsible Party | Date | Relationship (if patient is a minor)

PATIENT HEALTH HISTORY

Patient name: _____ Date of Birth: _____ Today's date: _____

Environmental History (please check all that apply)

RESIDENCE:
☐ House
☐ Apartment
☐ Mobile Home
☐ Other _____

REGION:
☐ City
☐ Small town
☐ Rural
☐ Farm/Ranch

HEATING SYSTEM:
☐ Gas
☐ Electric
☐ Forced Air
☐ Radiator
☐ Space Heater
☐ Fireplace

AIR CONDITIONING:
☐ Central
☐ Window Unit
☐ None

HUMIDIFIER:
☐ Yes
☐ No

BASEMENT:
☐ None
☐ Dry
☐ Damp
☐ Flooded in past

BEDROOM LOCATION:
☐ Basement
☐ First floor
☐ Second floor

BEDROOM FLOOR:
☐ Carpet
☐ Wood
☐ Vinyl
☐ Other _____

BEDDING/PILLOWS:
☐ Feather
☐ Polyester
☐ Foam
☐ Other _____

PETS:
☐ Dog (Number____ Years owned____) ☐ Outside ☐ Inside ☐ In bedroom
☐ Cat (Number____ Years owned____) ☐ Outside ☐ Inside ☐ In bedroom
☐ Other Animals (please list):_____

Social History

Do you currently smoke? ☐ Yes ☐ No If yes, how long? _____ Packs per day_____
Are you a former smoker? ☐ Yes ☐ No If yes, how long? _____ Packs per day_____
When did you quit? _____
Are you exposed to second hand smoke? ☐ Yes ☐ No If yes, please list where, ex: home, work: _____
Current Occupation: _____ How long? _____
Hobbies: _____
Exercise (type): _____ Frequency: _____
If the patient is a child, does he/she attend daycare? ☐ Yes ☐ No
Number of days missed from work/school due to your symptoms: _____

Past Allergy History

Previous allergy testing? ☐ Yes ☐ No
If yes, where and when? _____
Previous allergy shots? ☐ Yes ☐ No If yes, for how long? _____ Did allergy shots help? ☐ Yes ☐ No

Past Medical History (If more room is needed, please continue on back side of this paper)

Hospitalizations:

Reason	Date

Emergency Room Visits:

Reason	Date

Surgeries:

Reason	Date

PATIENT HEALTH HISTORY CONTINUED

Current Medications: (If more room is needed, please continue on back side of this paper)

MEDICATION	TAKEN FOR	DOSAGE	FREQUENCY

Immunization History

Are your routine immunizations up to date? ☐ Yes ☐ No

Date of last Influenza vaccine: _____ Date of last Pneumonia vaccine: _____

Family History

Please indicate whether there is a history of any of the following in your family:

	Allergies	Asthma	Eczema	Hives	Sinusitis
Mother					
Father					
Grandparent(s)					
Brother(s)					
Sister(s)					

Review of Systems

Please circle any symptom you are currently experiencing:

Category	Issues	No problems
General	Recent weight change Fever Chills Night sweats Weakness Fatigue	☐
Eyes	Pain Redness Watering Contact lenses/glasses Glaucoma Cataracts	☐
Ear/Nose/Throat	Hearing loss Vertigo (dizziness) Tinnitus (ringing) Sore mouth Dental problems	☐
Respiratory	Cough Respiratory infections Shortness of breath Wheezing	☐
Cardiovascular	High blood pressure Chest pain Palpitations Heart murmur Swelling of feet/ankles	☐
Endocrine	Heat/cold intolerance Diabetes Thyroid disorder	☐
Gastrointestinal	Abdominal pain Constipation Diarrhea Nausea Indigestion/heartburn Vomiting	☐
Musculoskeletal	Joint pain Muscle pain Muscle weakness Limitation of motion	☐
Genitourinary	Urinary infections Kidney problems	☐
Skin	Dryness Blistering Itching Hives Swelling	☐
Neurological	Fainting Seizures Numbness/tingling Memory loss	☐
Psychiatric	Depression Anxiety Insomnia ADD/ADHD	☐

Other relevant facts/information to assist in your care:

_____

_____

_____

Patient (or Guardian) Signature _____ Date _____

Physician Signature _____ Date _____