



11002 Veirs Mill Rd., Suite 414, Wheaton, MD 20902 (301) 962-5800 Fax (301) 962-9585
5454 Wisconsin Avenue, Suite 700, Chevy Chase, MD 20815 (301) 986-9262 Fax (301) 907-7910
Please visit our website: www.allergyasthma.us

Dear New Patient:

Thank you for selecting the Institute for Asthma & Allergy for your medical needs. On behalf of our physicians and staff we would like to welcome you to our Chevy Chase office.

On the day of your first appointment please be prepared to stay two hours or more. Our goal is to make each of your visits, from first to last, as effective, efficient and pleasant as possible. The following guidelines will help us to achieve this goal:

- 1) Please arrive 15 minutes prior to your appointment time to complete the registration process. It will help to expedite registration if you will verify the information on the guarantor's profile sheet and complete the registration form that is enclosed.
- 2) Be sure to have your insurance card and picture identification with you. Since your insurance has already been verified your co-pay will be collected prior to service. Your co-insurance or deductible will be collected in the office directly after services have been rendered. (For your convenience we accept cash, check, MasterCard or Visa).
- 3) If you are insured by an H.M.O. you must have a valid referral form from your primary care physician with you. Failure to bring a referral may result in having to reschedule your appointment. (*Special Note* it usually takes at least 48 hours to obtain a referral, so be sure to plan ahead.)
- 4) Please refrain from using any oral antihistamine for 7 days prior to your visit. We have enclosed a list of antihistamines for your convenience. Failure to comply will result in the postponement of any needed skin testing. ***If you are taking any asthma medication or antibiotics, please continue as prescribed.***
- 5) As a courtesy to our other asthma and allergy patients we ask you to refrain from using any scented products on the day of your visit. These products may cause a negative reaction in some patients.
- 6) For your convenience, our staff makes appointment reminder calls 1-3 days prior to your scheduled visit. All cancellations need to be made 24 hours in advance. If the office is closed, you may leave a cancellation message with our answering service. We have a missed appointment fee for failure to comply.
- 7) Please find a map of the area enclosed. We are located in the Barlow Building. The most convenient parking is behind the building on The Hills Plaza street entrance. There is a charge for parking. If you prefer to use the subway, take the red line to the Friendship Heights Station.

We look forward to meeting you. Should you have any questions please call (301-986-9262) during normal business phone hours.

Monday - Thursday 7:30am to 12:00 noon Monday & Thursday 1:00pm to 5:00pm
Tuesday 1:00 to 7:00pm Friday 7:00am to 5:00pm *note office closed 1 Wednesday monthly

Thank you,
The staff of the Institute for Asthma & Allergy

DIPLOMATES, AMERICAN BOARD OF ALLERGY AND CLINICAL IMMUNOLOGY
A CONJOINT BOARD OF INTERNAL MEDICINE AND PEDIATRICS

PATIENT CARE AND RESEARCH IN ASTHMA, RHINITIS, SINUSITIS, COUGH, URTICARIA, ANGIOEDEMA,
NASAL POLYPS, FOOD ALLERGY, ECZEMA, ANAPHYLAXIS, AND DRUG AND VENOM ALLERGY



Wheaton Tower South
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Chevy Chase, Maryland 20815
(301) 986-9262
Fax: (301) 907-7910

Please Print Clearly

Today's Date: _____

PATIENT INFORMATION

Patient Name			Home Phone #		
Home Address			City, State, Zip Code		
Social Security Number	Birthdate	Age	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep	
Drug Allergies, if any					
Patient Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student					
Employer			Occupation:		
Business Address		City, State, Zip Code		Business Phone, Ext.	

RESPONSIBLE PARTY

Responsible Party's Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other (specify)					
Name			Home Phone #		
Address			City, State, Zip Code		
Social Security Number	Birthdate			Age	
Employer			Occupation		
Employer Address			Business Phone, Ext.		
Person responsible for payment, if not same as above:				Home Phone #	
Home Address			City, State, Zip Code		

INSURANCE INFORMATION

Primary Insurance Company Name			Address		
Effective Date	Group #			Policy #	
Name of Policy Holder			Relationship to Patient		
Secondary Insurance Company Name			Address		
Effective Date	Group #			Policy #	
Name of Policy Holder			Relationship to Patient		
Name of Primary Care Physician				Phone #	
Address			City, State, Zip Code		

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that if this balance is not paid in a timely fashion, that I will be responsible not only for the balance due but any collection and/or reasonable attorney fees that are incurred in the attempt to collect this debt.

Print Name _____ Signature _____

Date _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to
The Institute for Asthma and Allergy for any services furnished to me by that physician.
I am aware that after 45 days, the outstanding balance becomes my responsibility and
the balance will be made in full unless other arrangements are made with the Billing Office.

Signature of Patient: _____ Date: _____

Institute for Asthma and Allergy

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Tel (301) 986-9262
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Michael A. Kaliner, MD Martha V. White, MD Athena Economides, MD H. Henry Li, MD, PhD Mark D. Scarupa, MD Eyal Oren, MD

POLICYHOLDER QUESTIONNAIRE

Due to recent HIPAA requirements, all of our patients are being asked to complete this form.

Please Print Clearly

Patient's Name: _____

Insurance Identification/Policy Number: _____

Name of Insurance Company: _____

1. Is the above insurance information NEW? Yes* No

*if you answered Yes to the above, please update your current information with the front desk.

2. Name of Policy Holder: _____

3. Relationship of Policy Holder to the Patient (check one):

- Mother Father Self
 Husband Wife Other:

4. Policy Holder's Employer: _____

5. Policy Holders Date of Birth: _____ / _____ / _____

Signature of Patient/Legal Guardian

Date

Name of Patient (if a minor)

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MEDICAL RECORDS RELEASE

I, _____, authorize the physicians of the Institute for Asthma and Allergy to report their medical findings to my Primary Care physician and/or other physicians or medical facilities that are deemed medically necessary for management of my healthcare.

I give permission for the physicians of the Institute for Asthma and Allergy to request my medical information from other specified physicians or institutions who may currently be providing care or may have provided treatment in the past.

I give permission for the mutual release of my medical or financial information associated with the Institute for Asthma and Allergy, specified insurance companies, attorneys or other agencies for billing, insurance coverage and/or financial concerns.

Signature of Patient/Legal Guardian

Date

Name of Patient (if a minor)

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EMERGENCY CONTACT

Patient's Name: _____

1. Name: _____

Relationship: _____

Telephone: _____ (home/work/cell)

Telephone: _____ (home/work/cell)

2. Name: _____

Relationship: _____

Telephone: _____ (home/work/cell)

Telephone: _____ (home/work/cell)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

INSTITUTE FOR ASTHMA & ALLERGY

Revised October 2003

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Institute for Asthma & Allergy's "NOTICE OF PRIVACY PRACTICES," revision date October 15, 2003.

As required by the Privacy Regulations, I am aware that Institute for Asthma & Allergy has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I understand that this office is not required to honor patient requested changes to the Institute of Asthma & Allergy's "Notice of Privacy Practices."

Signature

Date

Print Name

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____

Antihistamines

Discontinue at least 3 days prior to visit except as noted below

Accuhist	Periactin
Actifed with codeine cough syrup	Phenergan
Alavert <u>Discontinue 7 day prior to visit</u>	Rynatan
Allegra <u>Discontinue 7 day prior to visit</u>	Rondec and Rondec D
Allegra D <u>Discontinue 7 day prior to visit</u>	Sinulin
Allerx	Tavist D
Allerx D	Tamaril
Atarax <u>Discontinue 7 day prior to visit</u>	Trinalin
Atrohist	Tussend
Benadryl	Tussionex
Biohist	Tylenol PM
Bromfed	Semprex and Semprex D
Brompheniramine	Sinequan
Carbinoxamine	Viravan
Chlorpheniramine	Vistaril <u>Discontinue 7 day prior to visit</u>
Chlor-Trimeton	Zyrtec <u>Discontinue 7 day prior to visit</u>
Clarinox <u>Discontinue 7 day prior to visit</u>	Zyrtec D <u>Discontinue 7 day prior to visit</u>
Claritin <u>Discontinue 7 day prior to visit</u>	
Claritin D <u>Discontinue 7 day prior to visit</u>	
Clemastine	
Cyproheptadine	
D.A. Chewables	
Dimetapp Cough Syrup	
Doxepin	
Dura-Tuss	
Dura-Vent	
Extra Strength Pain Reliever/Sleep Aid	
Extendryl	
Hydroxyzine <u>Discontinue 7 day prior to visit</u>	
Kronofed	
Loratadine <u>Discontinue 7 day prior to visit</u>	
Nolahist	
Palgic	
PBZ Tablets	

If you have any questions regarding medications not listed, please contact your local pharmacy for further assistance to see whether it's an antihistamine.

Institute for Asthma & Allergy, P.C.

To our Patients

FORMS POLICY

In our ongoing effort to provide quality service to our patients the Physicians and staff of the Institute for Asthma & Allergy are happy to complete your various forms for Schools, Camps, Disabilities, Medications, Special needs etc.

Due to the amount of time and cost associated with the completion of these forms the Institute's charge for completion of all forms is \$25. If you have not been seen by the physician for an office visit within the last 2 months you will need an appointment to have the forms completed.

If forms are completed at the time of your office visit there will be no additional form charge. So please try and remember to bring your forms with you at the time of your office visit.

The form completion charge is not covered by your insurance plan therefore payment is expected at the time the form is presented to our office.

Please allow 48 hours for forms to be completed and remember to have your name and all demographic information completed as well as any special instructions attached to the form.

Thank You

The Physicians and Management



AT WASHINGTON
HOSPITAL CENTER

5454 Wisconsin Avenue, Suite 700 Chevy Chase, MD 20815 (301) 986-9262 Fax (301) 907-7910
1-800-ASTHMA-5

Directions from Rockville and Upper Montgomery County:

Take Rockville Pike/Wisconsin Avenue (Route 355) south toward Washington to Chevy Chase. The Barlow Building is at 5454 Wisconsin Avenue, across the street from Chevy Chase Shopping Center.

Directions from Virginia:

Take I-495 (Capital Beltway) north toward Rockville to River Road East (Exit 39). Follow River Road approximately four miles and turn left onto Willard Avenue. The Barlow Building is near the intersection of Willard and Wisconsin Avenues.

Directions from Washington:

Follow Wisconsin Avenue north to Chevy Chase. The Barlow Building is one block north of the Friendship Heights Metro Station.

