



PATIENT'S NAME: _____

Important Patient Information

- A patient must be accompanied by a parent or legal guardian unless he or she is legally and financially responsible for charges incurred in the course of treatment.
➤ Please notify our office at least five (5) days in advance if the patient will need a translator during the scheduled appointment.

APPOINTMENT INFORMATION

Time Scheduled: _____ [] AM [] PM Date Scheduled: _____

Your appointment is scheduled at

Table with 3 columns: Office Name, Address, and Zip Code. Includes locations like Eastover - Main Office, Ballantyne, Concord Office, Gastonia, Lake Norman, Monroe, Rock Hill, and University.

OUR OFFICES ARE OPEN AT 8:10 AM

➔ For directions please check our web site at www.carolinaasthma.com or contact us at 704-372-7900

Vitally Important Visit Information

- ▶ In order to have adequate time to complete the necessary paperwork, you should plan to arrive 15-30 minutes prior to your scheduled appointment time.
▶ Regarding Authorizations or Referrals: If you have TriCare Prime, V.A. or any of the HMO or POS plans, an authorization or referral is required prior to seeing a specialist.
▶ As a courtesy to our patients Carolina Asthma and Allergy Center calls new patients at least one week prior to the scheduled visit to confirm their appointment.
▶ Do not wear heavy perfume or colognes as they may be irritating to our allergy patients.
▶ Be prepared to pay your co-pay listed on your insurance card at the time of service.

Self-Pay Patients and Patients with High Deductible Plans

Self-pay patients and patients with high deductible plans are responsible for all charges incurred at CAAC and are expected to pay in full at the time of service. If you have any questions or concerns, please call us at 704-998-0812 prior to your appointment.



Dear Prospective Patient:

We are so pleased that you have chosen Carolina Asthma and Allergy Center (CAAC) to care for your asthma and/or allergy condition. In order to provide the best possible care, we request that you retain a primary care physician (PCP) for your general health problems. As a team (your PCP, our physicians, and our staff), we will work together to care for your asthma and allergy problems, but we do feel that your PCP is better equipped to treat your other illnesses. This creates optimum health care.

We have listed below some suggestions to enhance the quality of your experience with obtaining care at CAAC.

1. Contact your insurance company to determine:
 - a. If Carolina Asthma & Allergy Center is in your insurance network. **If we are not, you may be responsible for any or all charges for services rendered.**
 - b. If we are in your network, does your policy cover reimbursement for specialist consults, allergy testing, and allergy vaccines/injections?
2. Bring any medical records from your primary care physician or specialist(s) which you feel might be helpful to us in our assessment and treatment of your condition.
3. Please complete all of the enclosed forms prior to your visit.

Office Schedules

As you have chosen a particular CAAC office at which you wish to be seen, please familiarize yourself with the days of the week and the hours that specific office is open. This is especially important to our “shot” patients because of the limited days and hours available for your scheduled shots.

Our nursing staff is available Monday through Friday, 8:30AM to 5PM and is always available to answer emergency questions. Routine questions, however, may have to wait until later in the day, after your records have been accessed.

Our physicians are on-call for emergencies 24 hours a day and seven days a week. For non-emergency situations, we have provided a voice message that allows you to leave pertinent information regarding your situation which will be taken care of on the next business day.

Refills

Calling the pharmacy where you had the original prescription filled is the very best way to obtain refills of your allergy and asthma medications. Typically, we will write the original prescription for multiple refills and that will be on record at your pharmacy. Should there be no further refills, your pharmacy will call our office; we will review your record, and again give multiple refills, ***if you have routinely been seen in our office.*** (Due to the nature of our practice, other than an occasional cough preparation, we do not routinely prescribe narcotic medications.) As we do not have access to records on weekends, our physicians prefer not to prescribe or refill cough or most headache medications at that time. If you are in need of these medications, please request them during regular business hours, or you may consider contacting your primary care physician.

Follow-up Care

Your compliance is crucial to the success of your allergy program. Your allergist will advise you as to when you should return to discuss your progress. If at all possible you should schedule your return visit at the time of checkout. Depending upon your individual case, you may be asked to return anywhere from two weeks to 12 months.

If you are ill, rather than just walking-in, please call the office first and discuss your situation with the triage nurse. S/he may request that you come in to see the doctor or our physician's assistant. Please note that our physicians prefer not to prescribe antibiotics without having first examined our patients.

We appreciate your following these guidelines and assisting us in realizing our goal of providing you with the best available allergy and asthma health care.

Sincerely,

CAAC Physicians & Staff

Encl(s)



Date ____ / ____ / ____

History No.: _____

Patient Information	Race:		Ethnicity:		Preferred Language:		
	Mr.		Ms.		Mrs.	Dr.	
	First		MI		Last		
Street Address				E-Mail Address			
Mailing Address							
Zip		City			State		
Phone		Date of Birth					
SS#		Gender M <input type="checkbox"/> F <input type="checkbox"/>		Marital Status			
Occupation							
Employer				Employer Phone			
Address							
Zip		City			State		
Family Doctor							
Address							
Zip		City			State		
Referring Doctor							
Address							
Zip		City			State		
RESPONSIBLE PARTY	Mr.		Ms.	Mrs.	Dr.	DOB:	
	First		MI		Last		
	Street Address						
Mailing Address							
Zip		City			State		
Phone Home		Work		SS#			
Employer				Employer Phone			
Address							
Zip		City			State		
Relationship to Patient							

Insurance Information	Insured's Name	First	MI	Last	DOB
PRIMARY Insurer					
Mailing Address					
Zip	City			State	
Policy No.	Group No.			Plan	
Insurance Information	Insured's Name	First	MI	Last	DOB
SECONDARY Insurer					
Mailing Address					
Zip	City			State	
Policy No.	Group No.			Plan	
EMERGENCY NOTIFICATION NEXT-OF-KIN (not living with patient)					
Name					
Address					
Zip	City			State	
Phone	Home		Work		
PARENTS OF MINOR PATIENTS – NOT LISTED AS RESPONSIBLE PARTY					
Name				Mother	<input type="checkbox"/>
				Father	<input type="checkbox"/>
Address					
Zip	City			State	
Phone	Home		Work		
How did you hear about us?					
<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Internet <input type="checkbox"/> Advertisement <input type="checkbox"/> Physician <input type="checkbox"/> Other					
AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY					

“I authorize the release of any medical information necessary to process my insurance claim.”

Signed: Responsible Party _____ Date _____

PRE-VISIT QUESTIONNAIRE

In an attempt to serve you in a timely fashion, we are furnishing you with this questionnaire with the request that you complete this information prior to your scheduled visit. We look forward to seeing you.

CUESTIONARIO PREVIO A LA VISITA

En un intento por brindar servicios de manera oportuna, le solicitamos que complete este cuestionario que le suministramos antes de acudir a su visita programada. Esperamos verlo pronto.

Your Name ♦ Nombre	Date of Visit ♦ Fecha de su visita
Date of Birth ♦ Fecha de nacimiento	Acct.# to be filled-in by staff ♦ N.º de registro - para el personal

Current Medications and/or Supplements (e.g., vitamins) ♦ Medicamentos actuales y/o suplementos (p. ej., vitaminas)

(Please list all medicines you are currently taking for any reason) ♦ (Sírvase enumerar todos los medicamentos que toma actualmente por cualquier motivo)

Name of Medicine Nombre del medicamento	Dose Dosis	How often are you taking? Frecuencia	Name of Medicine Nombre del medicamento	Dose Dosis	How often are you taking? Frecuencia

Please document any medicines to which you are allergic and the type of reaction (e.g., rash) ♦ Sírvase enumerar todos los medicamentos que le provocan alergias y el tipo de reacción (p. ej., erupción cutánea)

Other Medical Conditions ♦ Otros problemas de salud

Past Allergy History ♦ Antecedentes de alergias

Have you seen an allergist in the past for your symptoms? ¿Ha acudido a un especialista en alergias debido a sus síntomas? Yes Sí No No

If yes: Doctor's Name Si acudió: Nombre del médico _____

When? ¿Cuándo? _____

Did you have skin testing? ♦ ¿Se le realizó una prueba cutánea? Yes Sí No No

Prior diagnosis ♦ Diagnóstico anterior

Allergic Rhinitis Rinitis alérgica Asthma Asma Hayfever Fiebre del heno Hives Irritación
 Eczema Eczema Urticaria Urticaria Insect sting Picaduras de insectos

Prior treatment ♦ Tratamiento anterior

None Ninguno Prescription meds Prescripción de medicamentos Allergy shots Inyecciones
 Over-the-counter meds Medicamentos de venta libre Avoidance measures Medidas especiales

General Childhood History ♦ Antecedentes generales de la niñez:

1. Were there any complications at birth? ♦ ¿Sufrió complicaciones durante el nacimiento? No No Yes Sí
 If "yes" please describe sírvase describirlas
2. Childhood illnesses ♦ Enfermedades de la niñez
 - Routine illnesses Enfermedades comunes
 - Recurrent ear infections Infecciones del oído recurrentes
 - Recurrent sore throat Dolor de garganta recurrente
 - Recurrent sinus infections Sinusitis recurrente
 - Skin Rashes Erupciones cutáneas
 - Respiratory difficulty Dificultad para respirar
 - Mumps Paperas
 - Measles Sarampión
 - Chickenpox Varicela
 - Allergies Alergias
 - Asthma Asma
3. Immunizations ♦ Vacunas
 - N/A N/D
 - Current Al día
 - Not Current No están al día

Family History

Please indicate if your family member has had any of the following:

Disease	Father	Father's		Mother	Mother's		Sister	Brother	Daughter	Son
		Mother	Father		Mother	Father				
Asthma										
Cystic Fibrosis										
Hay fever										
Eczema										
Heart disease										
Thyroid disease										
Arthritis/Lupus										
Bronchitis										
Food Allergies										
Migraine Headaches										
Diabetes										
Cancer										

Antecedentes familiares

Sírvase indicar si algún miembro de su familia tuvo alguna de las siguientes enfermedades:

Enfermedad	Padre	Abuela paterna	Abuelo paterno	Madre	Abuela materna	Abuelo materno	Hermana	Hermano	Hija	Hijo
Asma										
Fibrosis quística										
Fiebre del heno										
Eczema										
Enfermedades cardíacas										
Enfermedades de la										
Artritis/Lupus										
Bronquitis										
Alergias alimentarias										
Migrañas o cefaleas										
Diabetes										
Cancer										

Social History ♦ Antecedentes sociales

Child ♦ Hijos

1. Marital Status ♦ Estado civil:

- Married Casado/a
 Single Soltero/a
 Divorced Divorciado/a
 Separated Separado/a
 Widowed Viudo/a
 N/A N/D

2. Number of children ♦ Cantidad de hijos: _____

3. Do you smoke? ♦ ¿Es fumador? Yes **Sí** No **No** If yes **Si fuma:**
 less than 1 pk/wk **Menos de 1 paquete/semana** less than 1 pk/day **Menos de 1 paquete/día**
 1-2 pks/day **1 a 2 paquetes/día** more than 2 pks/day **Más de 2 paquetes/día**
4. How long have you smoked? ♦ ¿Hace cuánto que fuma?
 Less than 5 yrs. **Menos de 5 años** 5-10 years **5 a 10 años** 10-20 years **10 a 20 años** more than 20 years **Más de 20 años**
5. Have you stopped? ♦ ¿Ha dejado de fumar? Yes **Sí** No **No**
 If yes **Si dejó de fumar:** this year **Este año** 1-3 years ago **Entre 1 y 3 atrás** more than 3 years ago **Hace más de 3 años**
6. Are you exposed to secondary smoke? ♦ ¿Es fumador pasivo? Yes **Sí** No **No**
 If yes **Si es fumador pasivo:** Home **En su domicilio** Work **En su trabajo**
7. Do you chew tobacco or dip snuff? ♦ ¿Mastica tabaco o inhala tabaco en polvo? Yes **Sí** No **No**
8. Alcohol(wine/beer): ♦ **Alcohol (vino/cerveza):** No **No**
 Daily **A diario** Occasionally **Ocasionalmente** Weekly **Una vez por semana**
9. Days absent from school/work due to illness? ♦ ¿Cantidad de días que no asistió a la escuela o al trabajo por enfermedad?
 0 less than 5 **Menos de 5** 5-10 **Entre 5 y 10** 10-15 **Entre 10 y 15**
10. Occupation ♦ **Ocupación:** _____
 Are there any unusual exposures on the job? ♦ ¿Está expuesto a situaciones atípicas en su trabajo? Yes **Sí** No **No**
 If yes, please describe (e.g. toxins, mold) **Si la respuesta es afirmativa, sírvase describir tales situaciones (p. ej., toxinas, moho)** _____

Environmental History ♦ Información sobre el ambiente

Please check the appropriate boxes. (In some cases you may need to check more than one box) ♦ **Por favor, marque las casillas correspondientes. (En algunos casos puede que tenga que marcar más de una casilla).**

1. Home Location ♦ **Ubicación del hogar**
 Inner City **Centro de la ciudad** Urban(City) **Zona urbana (en la ciudad)** Suburbs **Periferia**
 Rural (Country) **Zona rural (en el campo)**
 Age of home **Antigüedad de la casa** _____
2. Home Type ♦ **Tipo de hogar:** Apartment **Apartamento** Condo **Condominio** House **Casa**
 Mobile Home **Casa remolque**
3. Air Conditioning ♦ **Aire acondicionado** None **No** Central **Refrigeración central**
 Window **Aire acondicionado de ventana** Ceiling fans **Ventiladores de techo** Window fans **Extractores**
4. Heat ♦ **Calefacción:** Baseboard **Zócalo radiante** Forced Air **Aire forzado** Electric **Eléctrica** Gas **A gas**
 Heat pump **Bomba de calor** Oil **A aceite** Radiant **Radiante** Radiator **Radiadores**
 Space Heater **Calefactores** Wood Stove **Estufa a leña**

5. Filters ♦ **Filtros:** None **No** Electrostatic **Electrostático** Fiberglass **Fibra de vidrio**
 Hypoallergenic **Hipoalergénico**
6. Mold ♦ **Formación de moho:** None **No** Baseboards **Zócalos** Basement **Sótanos** Bathroom **Baños**
 Crawl Spaces **Espacios angostos** Windows **Ventanas**
7. Bedroom Floor ♦ **Piso del dormitorio:**
 Area rug **Alfombras individuales** Cement **Hormigón**
 Full carpet Pile **Alfombra en toda la habitación:** Low **Grosor de la alfombra** Med **Pelo corto Intermedio**
 High **Pelo largo** with pad **Con relleno** no pad **Sin relleno**
 Hardwood **Madera** Linoleum **Linóleo** Tile **Baldosas**
8. Bedroom Windows ♦ **Ventanas del dormitorio:** Bare **Descubiertas**
Curtains Con cortinas: washable **lavables** non washable **no lavables**
 Miniblinds **Persianas americanas** Roll-up blinds **Persianas enrollables** Shades **Paneles**
 Plantation/Wooden blinds **Persianas de madera/Celosías**
9. Mattress ♦ **Colchón:** Old **Antiguo** New **Nuevo** Crib **De cuna** Foam **Gomaespuma**
 Inner spring **Resortes** Waterbed **Agua** Encased **Con funda** Not Encased **Sin funda**
10. Pillows ♦ **Almohadas:** Dacron **Dacrón** Feather **Plumas** Foam **Gomaespuma** None **Ninguna**
 Encased **Con funda** Not Encased **Sin funda**
11. Objects in bedroom ♦ **Objetos en el dormitorio:**
 Cluttered **Desordenados** Somewhat cluttered **Un poco desordenados** Uncluttered **Ordenados**
12. Pets ♦ **Mascotas:** Cats **Gatos** Dogs **Perros** Indoor **En el interior de la casa** Outdoor **Fuera de la casa**
Other animals ♦ Otros animales: Bird **Aves** Hamster **Hámsteres** Horse **Caballos** Gerbil **Jerbos**
 Rabbit **Conejos** Farm Animals **Animales de granja** Indoor **En el interior de la casa**
 Outdoor **Fuera de la casa**
13. Hobbies/Sports ♦ **Pasatiempos/Deportes:** None **No** Indoor **En interiores** Outdoor **Al aire libre**

 Physician's Signature

 Date



PROTECTED HEALTH INFORMATION
CONSENT TO THE USE AND DISCLOSURE

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by the Carolina Asthma and Allergy Center or disclosed as per Federal guidelines for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. The Carolina Asthma & Allergy Center will practice according to our Privacy Policy.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Carolina Asthma and Allergy Center may or may not agree to restrict the use or disclosure of your protected health information. If Carolina Asthma and Allergy Center agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Reservation of Right to Change Privacy Practices

Carolina Asthma and Allergy Center reserves the right to modify the privacy practices outlined in the notice.

“I have reviewed this authorization form and give my permission to Carolina Asthma and Allergy Center to use and disclose my health information in accordance with it.”

Name of Patient (Print or Type)	Signature of Patient	Date Signed
Signature of Patient Representative	Relationship of Patient Representative to Patient	



PROTECTED HEALTH INFORMATION
Authorization for Release of Information

Name of Patient _____ Date of Birth _____
 _____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information	Description of Information To Be Released
Check each person/entity that you approve to receive the information <input type="checkbox"/> Voice Mail	Check each item on the left in the same section that can be given to person/entity <input type="checkbox"/> Results of lab tests/x-rays or <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse (provide name and telephone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Parent (provide name and telephone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Other (provide name and telephone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that this authorization shall be in effect until revoked by the patient.

Signature of Patient _____ Date _____

Description of Personal Representative's Authority (attach necessary documentation)

Special Medication Instructions

Many medications interfere with skin testing. Below is a list of medications to avoid prior to testing. (Never stop any medications without first checking with the prescribing physician.)

One week prior to your skin testing appointment:



(Please ask your prescribing doctor for clarification of Antihistamines)

Stop antihistamines such as: **Alavert**, **Allegra** (*fexofenadine*), **Clarinox**, **Claritin** (*loratadine*), **Dallergy**, **Xyzal** (*levocetirizine*), and **Zyrtec** (*cetirizine*). **Astelin** (*azelastine*), **Astepro** and **Patanase** nasal sprays will also need to be stopped.

If you are taking **Doxepin**, this also should be discontinued seven days prior to skin testing.



Antihistamines such as: **Actifed**, **Aerohist**, **AlleRx**, **Arbinoxa** (*carbinoxamine*), **Atarax**, **Chlor-Trimeton** (*chlorpheniramine*), **Dimetapp** (*brompheniramine*), *hydroxyzine*, **Palgic** (*carbinoxamine maleate*), **Phenergan** (*promethazine*), **QDall**, **Tavist** (*clemastine*), **Tussionex**, and **Vistaril**.

If your symptoms are unbearable, you may use **Benadryl** (*diphenhydramine*) up to (3) days prior to visit.



Discontinue any antihistamine-containing eye drops such as **Alaway** (*ketotifen fumarate*), **Bepreve** (*bepotastine besilate*), **Claritin Eye** (*ketotifen*), **Elestat** (*epinastine HCl*), **Emadine** (*emedastine difumurate*), **Lastacaft** (*alcaftadine*), **Naphcon-A** (*naphazoline HCl*), **Optivar** (*azelastine HCl*), **Pataday** (*olopatadine HCl*), **Patanol** (*olopatadine HCl*), **Visine-A** (*naphazoline HCl*), **Zaditor** (*ketotifen fumarate*), and **Zyrtec Itchy Eye** (*ketotifen fumarate*),

There are multiple prescription and non-prescription combination medications that contain an antihistamine, please check the ingredients. You can also check with your pharmacist or our office for assistance.

- You may continue all **non-antihistamine** eye drops.
- Asthma medications should be continued, as they do not interfere with testing.

- Please bring all medications (including over-the-counter and vitamins) with you.
- For your convenience and to avoid delays, we encourage you to complete your new patient paper work in advance. Please visit our website at carolinaasthma.com where you can retrieve the new patient documents to be completed, as well as the directions to our offices.
- You are requested to arrive at our office at least 20 minutes prior to your appointment. Remember also to bring your insurance card and be prepared to pay your co-pay at check-in.
- Please allow up to three (3) hours for your initial appointment.

We look forward to seeing you. Should you find that you are unable to keep this appointment, please contact our scheduling department at **704-372-7900** or E-mail our office at appointments@carolinaasthma.com at least 24 hours in advance, to avoid the \$25 missed appointment fee.

Thank you.

The Carolina Asthma and Allergy Center Team

Medical Record Requests and Patient Completion Forms Policy

North Carolina law requires that a provider furnish copies of medical records to a patient within 30 days from receipt of the initial request. Additionally, the provider is allowed to charge a reasonable fee for copying and postage.

Carolina Asthma & Allergy Center will complete patient medical forms as follows:

School Forms and Skin or Lab Test Requests

1. **No fee** will be charged for:
 - a) The completion of school forms such as school medical or college health forms.
 - b) Skin and lab test requests will be given to the patient for free.
2. **Prior to your office visit** the form should be given to the Front Desk Staff and will be completed and returned to you by the Clinical Staff during the visit.
3. Carolina Asthma & Allergy will make best efforts to send your medical records to you in the format requested as long as it's in a secure manner. Due to security concerns, we are reluctant to send copies of medical records by e-mail or fax. Fax requests will only be sent to a designated recipient. It is our policy not to send medical records via email.

Life Insurance Claims, Disability Forms, Attorney Requests, Family Medical Leave Of Absence (FMLA) Forms, and Medical Record Requests

These forms will be completed and/or medical records requested will be sent after the following fee is paid.

In accordance with the NC general statute 90, Carolina Asthma & Allergy requires the following amounts be paid. The maximum fee for each request shall be:

- Seventy-five cents (75¢) per page for the first 25 pages,
- Fifty cents (50¢) per page for pages 26 through 100, and
- Twenty-five cents (25¢) for each page in excess of 100 pages.

All Forms Received By Mail or Dropped Off At Our Office

Carolina Asthma & Allergy Center will make best efforts to complete and return these to the patient or parent, within fifteen (15) business days but not greater than thirty (30) days.



Authorization to Pay Benefits to Physician

I authorize and request payment of the medical and/or major medical benefits directly to my physician. This authorization will cover all medical services rendered until a written notice of cancellation is received in this office.

I understand the amounts paid by my insurance company to my physician for specific services rendered may change from time to time and that any payment amounts requested at checkout or insurance adjustments appearing on my visit summaries and statements are estimates. As such, upon receiving final accounting and payment from my insurance company, an additional payment may be required of me to settle my account.

I understand that I am financially responsible to my physician for charges not covered or paid by the assignment.

Signed (Patient or Representative)

Date

Authorization To Release Information To Insurance Company

I authorize the release of any medical information necessary to process my insurance claims.

Signed (Responsible Party)

Date



FINANCIAL POLICY

Thank you for choosing Carolina Asthma and Allergy Center (CAAC) for your healthcare needs. CAAC is committed to providing you with the highest quality medical care in a cost effective manner. In order to achieve our goal of providing the best possible medical care and to maintain a strong financial position, we will work with you to ensure you are aware of our financial policies and your potential payment responsibilities; as well as implement and adhere to this financial policy. The following statements represent our financial policy:

Identification

For the protection of our patients in order to reduce medical identify theft, all patients are required to present a valid insurance ID card and driver's license at the time of service. If a driver's license is unavailable a valid photo ID must be presented.

Insurance & Insurance Verification

On our website, CAAC provides a list of insurance carriers with whom we are participating. If your insurance carrier is not listed, we recommend that you contact them directly to confirm that CAAC is a participating provider. CAAC employees will make the best effort to inform all patients prior to their visit if we are not participating with their insurance carrier. However, the ultimate responsibility belongs to the patient.

It is sometimes difficult for us to determine which services will be covered, since benefit coverage varies from plan to plan. Insurance Carriers have the final say regarding all coverage decisions, and may determine that certain services are not eligible for payment due to medical policy guidelines and exclusions contained in their respective plans. Patients will be billed for services deemed non-covered by their insurance carrier. Verification of benefits is not a guarantee of payment. CAAC does not file claims to tertiary (third party) payers.

Non Participating Insurance

In the event CAAC is not participating with your insurance carrier we will file your insurance as a courtesy to you. You will be responsible for the difference between your insurance payment and our billed charges.. Should your insurance carrier pay you directly, you agree to forward full payment with a copy of the explanation of benefits (EOB) within 10 days of receipt of your insurance payment.

Self-Pay and High-Deductible Patients

Self-pay patients are responsible for all charges incurred at CAAC and are expected to pay in full at the time of service. If you are unable to pay in full at the time of service there are options that can be discussed. We are participating with Care Credit, a health care credit card. Payment arrangements may be an option when approved prior to services being provided.

Missed Appointments

CAAC has a waiting list for appointments especially during allergy season and requests all patients be considerate of other patients when needing to cancel or reschedule an appointment. A \$25 missed appointment failed fee will be charged to all patients unless the appointment was canceled or rescheduled at least 24 hours in advance. For your convenience you can notify us by calling our office at 704-372-7900 or via email at scheduling@carolinaasthma.com.

Payment Options

As a courtesy to our patients we accept personal checks, credit cards, cash, or money orders. Payments can be made online via our website at www.carolinaasthma.com, via mail, in person at any of our CAAC locations, or by calling our office at 704-372-7900.

Bad Debts / Outside Collection Agencies

Patients with unpaid delinquent balances or balances sent to a collection agency will be required to make satisfactory arrangements or settle the balance before receiving future services. Balances that cannot be collected after our in-house collection procedures may be referred to an outside collection agency and patients are responsible for the collection agency fees. Patient will also be responsible for all fees associated with non-sufficient funds (NSF). CAAC reserves the right to discharge or refuse services to patients for non-payment of services.

Refunds

CAAC will make best efforts to refund overpayments to the appropriate party within 30 days. Patient refunds will not be processed until all active or past due accounts for patients or dependents are paid in full. Refunds of less than \$3.00 will not be issued to the patient unless specifically requested.

I hereby acknowledge that I have read and agree to abide by the above financial policy.

Signature of Patient or Responsible Party

Date