West Hills Allergy & Asthma Associates

Dear

Thank you for entrusting West Hills Allergy & Asthma Associates with your care. Please review and complete the attached new patient paperwork and bring it with you to your appointment.

You are scheduled on {insert appt date} at {insert appt time} with L Rene Anderson Cowell, MD and our address is 9701 SW Barnes Rd, Suite 130, Portland OR 97225.

- **Your specialist office visit benefits are: {INSERT BENEFITS}.**
- **As advised by your insurance company, quoted benefits are not a guarantee of coverage or payment and will be subject to medical necessity and plan benefits at the time services are rendered. Any charges not covered by insurance become the patient's responsibility.**
- **Your insurance does require a referral in order for you to see specialists. You will need to contact your primary care provider to request that. If a referral is not in place the day prior to your appointment, we will contact you to reschedule.**

Here are some reminders regarding your new patient appointment:

- **You should arrive 15 minutes prior to your appointment time.**
- **We do not guarantee allergy testing at the first appointment.**
- **You will need to stop taking any over-the-counter antihistamines at least 3-5 days before your appointment. You do not have to stop using any nasal sprays or inhalers.**
- **Please bring your ID, insurance card, any appropriate copay amount, a current medication list, and the completed new patient paperwork with you.**
- **We are a fragrance-free clinic, so please refrain from wearing any fragrances or scented skin/haircare products on the day of your appointment.**

If you cannot make this appointment, please contact us at least 24 hours prior to your appointment to avoid a missed appointment fee of $75.00. If you have any questions regarding any of these forms, or if you need to reschedule your appointment, please contact us at 503-294-6149, then option 1 for new patients.

Sincerely,

West Hills Allergy & Asthma Associates, LLC

Patient: **DOB:**

MR#: **Provider:** **L Rene Anderson Cowell, MD**
Date: _____

Reason for visit: _____
Please circle any that you, or a parent/sibling, have been diagnosed with:

	Patient	Parent/Sibling - What relationship	
Asthma/COPD	Yes	Yes	
Pneumonia/Bronchitis/Croup	Yes	Yes	
Sinusitis-Rhinitis	Yes	Yes	
Nasal Polyps	Yes	Yes	
Sleep Apnea	Yes	Yes	
Otitis-ear tubes	Yes	Yes	
Eustachian dysfunction	Yes	Yes	
Tinnitus	Yes	Yes	
Conjunctivitis	Yes	Yes	
Blepharitis	Yes	Yes	
Glaucoma	Yes	Yes	
Eczema	Yes	Yes	
Hives-Urticaria-Angioedema	Yes	Yes	
Anaphylaxis	Yes	Yes	
Mastocytosis	Yes	Yes	
Latex Allergy	Yes	Yes	
Drug Allergy	Yes	Yes	
Sting Allergy	Yes	Yes	
Food Allergy	Yes	Yes	
Immune deficiency	Yes	Yes	
Autoimmunity	Yes	Yes	
Heartburn-GERD	Yes	Yes	
Esophagitis/Gastritis/Colitis	Yes	Yes	
Hypertension	Yes	Yes	
High Cholesterol	Yes	Yes	
Heart disease/Stroke	Yes	Yes	
Diabetes	Yes	Yes	
Arthritis	Yes	Yes	
Menopause	Yes	Yes	
Prostate problems	Yes	Yes	
Hypo-Hyper Thyroidism	Yes	Yes	
Cancer	Yes	Yes	
Contagious illness	Yes	Yes	
Hepatitis-TB	Yes	Yes	
Depression-Anxiety	Yes	Yes	

Patient Name: **MR#:** **Date:** _____

Occupation: _____

1. Do you have any concern for exposure at work? **No / Yes**

2. Please list your hobbies and favorite activities: _____
_____
_____

3. What is your living situation (circle one): House Apartment Condo Mobile Home Townhouse

4. Your home was built: _____ Year moved into home: _____

5. Heating/cooling in home (circle one): Electric Gas Radiant Fireplace/Stove AC/Filter

6. Flooring in home (circle all that apply): Area Rugs Hardwood Laminate Carpet (Last cleaned _____)

7. Have you had any of the following in your home (circle all that apply):
Leaks Flood Poor ventilation Mold Mice Rats

8. Type of bed do you have: Traditional Mattress Foam Mattress Water Bed Other_____
Mite Covers: **No / Yes**

9. Pets/animals in your home: **No / Yes**
Cats: How many:_____ In house: **No / Yes** In bedroom: **No / Yes**
Dogs: How many:_____ In house: **No / Yes** In bedroom: **No / Yes**
Birds: How many:_____ In house: **No / Yes** In bedroom: **No / Yes**
Other: Type_____ How many:_____ In house: **No / Yes** In bedroom: **No / Yes**
Barn exposure/horses: **No / Yes**

10. History of smoking? **No / Yes** Packs per day: _____ Age quit: _____

11. Alcoholic beverages (circle one): Never Socially Daily (average drinks per day: ____)

12. Recreational or Medicinal drug use? **No / Yes**

Medical History:

13. Prior testing/positives: _____
Where/when previous testing done: _____
Allergy shots: Currently on shots: **No / Yes**
Previously had shots: **No / Yes** (end date: _____)

14. Hospitalizations/surgeries (include dates): _____
_____

15. ER Visits (include dates): _____
_____

16. Intubations due to respiratory failure: **No / Yes**

17. Oral steroids: **No / Yes #** of times per year: _____
Inhaled steroids (includes nasal sprays): **No / Yes** Do you use them: All the time / With flares
Albuterol use: **No / Yes**

18. Antibiotic Use: **No / Yes #** of times per year: _____

19. Yeast infections: **No / Yes**

Patient Name: **MR#:** **Date:**_____

Please mark C if this is a symptom you are currently experiencing. Please mark P if this is a symptom you have experienced in the past.

Constitutional	**C**	**P**
Fatigue		
Insomnia		
Malaise		
Weight Gain		
Weight Loss		

HEENT	**C**	**P**
Bad breath		
Eye redness		
Eye itching		
Eye tearing		
Eye discharge		
Ear drainage		
Ear pain		
Ear infections		
Bloody nose		
Facial pain		
Frequent sore throat		
Frequent throat clearing		
Hearing loss		
Hoarseness		
Impaired smell		
Itchy throat		
Nasal congestion		
Nasal drainage		
Post nasal drip		
Sinus pressure		
Trouble swallowing		

Respiratory	**C**	**P**
Cough		
Chest Tightness		
Frequent colds		
Pain		
Shortness of breath		
Wheezing		
Sleep Apnea		

Psychiatric	**C**	**P**
Anxiety		
Depression		

Gastrointestinal	**C**	**P**
Abdominal pain		
Belching		
Change in appetite		
Diarrhea		
Flatulence		
Loss of appetite		
Nausea		
Vomiting		

Musculoskeletal	**C**	**P**
Joint Pain		
Joint swelling		

Integumentary	**C**	**P**
Dry skin		
Hair loss		
Hives		
Itching		
Rash		
Skin lesion		
Eczema		

Neurological	**C**	**P**
Abnormal sleep pattern		
Dizziness		
Fainting		
Headaches		
Seizures		

Metabolic/Endocrine	**C**	**P**
Change in sleep/wake pattern		
Decreased activity		

Immunologic	**C**	**P**
Contact allergy		
Environmental allergies		
Food allergies		
Seasonal allergies		
Bee sting allergy		

West Hills Allergy Asthma Associates

Patient:
DOB: **Visit Date:**
MR#: **Provider:** **L Rene Anderson Cowell, MD**

Medication List

Please list all medications that you take, including over-the-counter medications.

Medication	Dosage/Strength	Frequency

West Hills Allergy & Asthma Associates

Patient:
DOB:
MR#: **Provider:** **L Rene Anderson Cowell, MD**

PATIENT FINANCIAL AGREEMENT

West Hills Allergy & Asthma Associates has adopted the following financial policy to communicate with our patients the expectation of payment for services rendered. Understanding your financial responsibilities is an integral part of your care and treatment.

Insurance Claims/Payment: As a courtesy West Hills Allergy & Asthma Associates will file your insurance claims for you; however, in the event that your insurance company denies payment for any reason the guarantor will be responsible for any balance due. It is the guarantor's responsibility to provide current insurance information, including the insurance subscriber number and mailing address, and to follow up on any benefit questions with the insurance carrier. We must emphasize that we are a medical care provider; our relationship is with the patient and not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

West Hills Allergy & Asthma Associates does not treat worker's compensation injuries or illnesses. If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs regardless of pending lawsuits.

Patient Account Charges: We require payment of Co-pays at the time of your scheduled visit.

Self-Pay Patients: **If you DO NOT have proof of insurance, you will be considered a self-pay patient.**
If patients are not covered by health insurance plans the patient will be asked to pay a $400 deposit for the initial visit and a $250 deposit for each subsequent visit prior to the scheduled appointments. The deposit will be applied toward balances owed by the patient and any over-payment will be refunded.

Payments: We accept cash, checks or credit cards. We reserve the right to require payments for services to be made at or before the time of service.

No Show and Cancellation Charges: As a courtesy to our physicians, staff and other patients, we ask that you cancel your appointment at least 24 hours in advance. There is a $75 fee for not showing up for or cancelling your appointments with less than a 24 hour notice.

Divorced/Separated Parents: Please be advised that the party initiating the treatment and signing this Patient Financial Agreement will be responsible for amounts owed West Hills Allergy & Asthma Associates. We do not get involved in any custody dispute or financial responsibility dispute between parents or other responsible parties.

I understand that I am required to pay West Hills Allergy & Asthma Associates for services I received in accordance with this agreement. I agree to pay all amounts owed West Hills Allergy & Asthma Associates within 30 days from the billing statement date.

AGREEMENT AND NOTICE OF POLICIES is deemed financially responsible for the account
I authorize my health insurance or third party payer to make payments directly to West Hills Allergy & Asthma Associates I understand that all payments from my health insurance plan or third party payer will be applied to my account. I authorize West Hills Allergy & Asthma Associates to release any information acquired in the course of examination and treatment to my insurance plan or third party payer.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Patient Printed Name Date

West Hills Allergy & Asthma Associates

Patient:
DOB:
MR#: **Provider:** **L Rene Anderson Cowell, MD**

Medication Refill Policy

Refill requests on previously prescribed medications are an important part of the ongoing care West Hills Allergy & Asthma Associates provides to our patients.

To obtain a prescription refill, you must:

1. **Call your pharmacy first to ask for a refill request.**
2. **The pharmacy will then fax us the refill request.** (Fax number 503-297-0499)

Plan ahead and allow 3 to 4 days for this to process. If you use mail order allow up to 14 days before your medication is due to run out.

It is our policy to review every refill request within **one to two business days** from the date we receive the request from the pharmacy (during standard hours of operation.)

Refill request may be denied if we have not seen or monitored you for your condition for a certain period of time, depending upon the particular health condition. Most medication refills require a 1 year follow-up visit; in some cases depending on the medication, a medication a patient may need a sooner follow-up visit.

If a follow-up visit is needed, please call us at 503-294-6149.

No prescriptions will be refilled or reviewed on Fridays, Saturdays, Sundays, holiday breaks or by the on-call physician.

Prescriptions received after 3:30 PM may be reviewed the following day within our standard hours of operations.

West Hills Allergy & Asthma Associates St. Vincent/Peterkort standard hours of operation:

Monday – Thursday 8:00 AM – 5:00 PM

By signing below, I understand, agree, and accept the policy on medication refills.

Patient name: please print: _____

Patient/Guardian signature: _____ Date_____

West Hills Allergy & Asthma Associates

Patient:
DOB:
MR#: **Provider:** **L Rene Anderson Cowell, MD**

HIPAA Patient Consent Form

I, , date of birth , medical record number understand that as part of my health care, West Hills Allergy & Asthma Associates (WHAAA) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A means by which a third-party payer can verify that services billed were actually provided, and

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

_____ (***Initial)*** I agree to allow WHAA physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following:

Please initial next to the applicable communication devices:

_____(***Initial*****)** Home # _____ Cell #_____ Work # _____

_____(***Initial)*** **NO,** I do not agree to allow WHAAphysicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

_____ (***Initial)*** I agree to allow WHAA physicians and healthcare staff to speak with only the following people regarding my Protected Healthcare Information.
List Name(s), relationship and phone number:

(print name)	(relationship)	(phone number)
(print name)	(relationship)	(phone number)
(print name)	(relationship)	(phone number)

_____ _____ _____
Patient Name (Please Print) Signature of Patient (or Patient's Legal Representative)

Date _____

Patient Refused to Sign: _____ _____
Staff Name Date