Mid-Cities Allergy & Asthma Clinic
Eugene Posnock, M.D., P.A.
Purnima Venkatesh, M.D., P.A.

New Patient Welcome Letter

Dear New Patient:

Welcome to our practice! Thank you for choosing Mid-Cities Allergy & Asthma Clinic for your allergy and asthma care. Dr. Posnock and Dr. Venkatesh look forward to taking care of your allergy and asthma needs, ultimately resulting in you and your family's improved health and well-being.

Since you are a new patient to us, we would like to introduce ourselves to you and familiarize you with our practice. Dr. Posnock is board certified in Allergy & Immunology and has been in practice in the Mid Cities for over 20 years. Dr. Venkatesh is also board certified in Allergy & Immunology and has been practicing in North Texas since 2004 and joined Dr. Posnock in 2007.

We realize you have high expectations from your physicians, and our first and foremost goal is to exceed those expectations. Your initial visit with the Allergists at Mid-Cities Allergy & Asthma Clinic will involve a detailed consultation with the physician, possible testing, and a tailored treatment plan. This individualized care can result in a new patient appointment lasting **2-3 hours**. When making your new patient appointment, please budget your time accordingly. It is very helpful if you have all your new patient forms completely filled out beforehand. If you prefer to fill out your forms at the clinic, please arrive 15 minutes prior to your appointment time.

When indicated, allergy skin testing to airborne allergens (pollens, molds, dust mites, animal dander) and/or foods can assist the doctor in diagnosing your condition. We cannot guarantee that allergy skin testing will be performed at your initial visit. This will be determined by the physicians. Should allergy testing be performed, all forms of antihistamines must be stopped for 5 days prior to the test. However, patients with hives should continue their antihistamines.

Please bring all medications and supplements that you are currently taking to your initial appointment. Also bring or arrange to have sent any relevant medical records **prior** to your appointment so that our physicians have the time to review them.

Due to the nature of our practice, we ask that patients refrain from wearing perfume and other fragrances which can irritate sensitive individuals. Our office is a smoke-free environment and smoking is not permitted anywhere in the building or near entryways. Due to our patients with food allergies, no food is permitted in the waiting room or exam rooms. We ask that you please respect these policies in the best interest of all our patients.

With all of the information and education you will undoubtedly receive after your visit at Mid-Cities Allergy & Asthma Clinic, it is easy to feel overwhelmed. Please feel free to call our office with any questions you may have after your consultation.

Again, thank you for choosing Mid-Cities Allergy & Asthma Clinic. Drs. Posnock and Venkatesh and their staff look forward to a wonderful relationship with you and your family.

Sincerely,
The Staff at Mid-Cities Allergy

2305 Central Park Blvd. * Bedford, TX 76022 * 817-571-6622 phone * 817-868-1962 fax

Mid-Cities Allergy & Asthma Clinic

Patient Information

Patient Name: ______________________________ ______ Date: ____________
Last name First name MI

Address: ______________________________ City: ____________ Zip Code: ________
Street Apt#

Home Phone: ____________ Work Phone: ____________ Cell: ____________

Date of Birth: ____________ Age: ________ Sex: ☐ male ☐ female ☐ M ☐ S ☐ D ☐ W
Marital Status

Drivers License#: ______________________________ State:__________

Patient's Employer: ____________________ Occupation: ____________________

Employer's Address: ____________________ City: ____________ Zip Code: ________

Spouse's Name: ______________________________ Date of Birth: ____________

Spouse's Employer: ____________________ Work Phone: ____________________

IF PATIENT IS UNDER 18 YEARS OF AGE/OR IF ON PARENT'S INSURANCE:

Mother's Name: ____________________ Home Phone: ____________________
Address: ____________________ City: ____________ Zip Code: ________
Employer's Name: ____________________ Work Phone: ____________________

Father's Name: ____________________ Home Phone: ____________________
Address: ____________________ City: ____________ Zip Code: ________
Employer's Name: ____________________ Work Phone: ____________________

CONTACT INFORMATION:

Check where you can be reached during business hours: ☐ Home ☐ Work ☐ Cell

May we contact you at home? ☐ Yes ☐ No May we contact you at work? ☐ Yes ☐ No

Check where we may leave messages about appointments, lab/x-ray results, or other healthcare information:

☐ Yes ☐ No Home answering machine/voicemail
☐ Yes ☐ No Cell phone
☐ Yes ☐ No Family Member
☐ Yes ☐ No Work voicemail
☐ Yes ☐ No Co-Worker

I hereby give permission to Mid-Cities Allergy & Asthma Clinic to disclose any information related to my medical conditions to the following persons (e.g. spouse, significant other, relative, friend, school/school nurse):

Name: ______________________________ Relationship: ____________________
Name: ______________________________ Relationship: ____________________
Name: ______________________________ Relationship: ____________________

Emergency Contact: ____________________ Relationship: ____________________
Contact #: ____________________

Preferred Pharmacy: ____________________ Tel: ____________________

Name of Referring Doctor:

Mid-Cities Allergy & Asthma Clinic

Insurance Information

Patient Name: ___________________________ ___________________________ ______ Date: _________________
Last name First name MI

Primary Insurance Information:

Insurance Company's Name: ____

Insurance Address: ____

City: _________________________ State: _________ Zip: ____________________

Insurance Phone Number: __________________________ Specialist Copay: $__________________

Policy ID#: ________________________________ Group#: _____________________________

Primary Policy Holder's Full Name: ____

Primary Policy Holder's: Date of Birth: ___________________ Social Security#: ________________________

Employer: ____

Primary Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _______________

Secondary Insurance Information: Do you have other insurance coverage? ☐ No ☐ Yes If yes, please fill out:

Insurance Company's Name: ____

Insurance Address: ____

City: _________________________ State: _________ Zip: ____________________

Insurance Phone Number: __________________________ Specialist Copay: $__________________

Policy ID#: ________________________________ Group#: _____________________________

Primary Policy Holder's Full Name: ____

Primary Policy Holder's: Date of Birth: ___________________ Social Security#: ________________________

Employer: ____

Primary Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _______________

I understand that I am required to give my current insurance card, driver's license, and any other billing information for statements and contracted insurance to be filed on my behalf. I agree to notify Mid-Cities Allergy & Asthma Clinic of any changes in my insurance or billing information as soon as they occur. If this is not done, I will be responsible for all charges incurred because of timely filing required by my insurance. I am also responsible for services performed but denied by my insurance company as "non-covered" or "not medically necessary". I authorize treatment for the patient named above and am the responsible party for all charges. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of such claims and that all proceeds of insurance will be assigned to either Eugene Posnock, M.D. or Purnima Venkatesh, M.D. I authorize the release of any medical information necessary to process insurance claims.

Patient/Parent Signature: ____ Date: ________________________

Mid-Cities Allergy & Asthma Clinic

Medical Services Financial Agreement

Thank you for choosing Mid-Cities Allergy & Asthma Clinic for your health care needs. It is our hope that the following financial policies will be helpful and reduce misunderstanding or confusion as we pursue payment for the medical services we provide. Please speak to a receptionist if you have any questions regarding these policies.

Payment for Services

Payment for services is due at the time services are rendered. For patients without insurance, payment in full is due at the time of service. For patients with insurance, such payment includes any co-payment, deductible, co-insurance, and all fees associated with non-covered services. We accept cash, checks, MasterCard, Visa, Discover, and American Express. Returned checks will result in a **$30** administrative fee that will be posted to your account. Returned checks or outstanding balances older than 90 days may be subject to external collection. If it becomes necessary to forward your account to a collection agency, in addition to the amount owed, you will be responsible for all collection fees, and attorney and court fees.

Medical Insurance

If we are contracted with your medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this, you must provide our office with all relevant information, including copies of your health insurance card and drivers license. It is your responsibility to make sure we have your current information on file prior to receiving care. This information will be used to verify your insurance benefits. If you are unable to provide complete insurance information for benefit verification, you are responsible for full payment at the time of service.

Please understand that the ultimate responsibility for ensuring complete payment is made lies with you, not your insurance company. As a courtesy to our patients, we will gladly submit your claim to the insurance company. However, we cannot guarantee your insurance will pay these claims since the insurance company will only "quote" your benefits, they never "guarantee" these benefits. If your insurance has not paid a claim within 60 days of billing, any unpaid professional fees are due and payable in full from you within 30 days of your statement date.

Your health insurance is a contract between you, your employer (if applicable), and your insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

Referrals

If you have an insurance plan that requires a referral (e.g., an HMO plan), it is your responsibility to obtain a referral from your primary care provider prior to your first scheduled appointment and keep it current for every visit thereafter.

Cancelled Appointments

Missed appointments represent a cost to us and to other patients who could have been seen in the time that was set aside for you. Therefore, cancellations must be requested at least 24 hours prior to the scheduled appointment time. Failure to cancel or show for a scheduled appointment may result in a **$25** administration fee. Failure to cancel or show for a special procedure (e.g., patch testing, Rush immunotherapy, etc.) may result in a **$50** administrative fee. These fees are not billable to your insurance.

Medical Records

We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Requests for medical records will be processed within 15 business days as mandated by the Texas Board of Medical Examiners and will be subject to a processing fee as determined by the Medical Board.

Medication Refills

Please call your pharmacy to request a refill of your medication(s). Prescription refills may take 24-48 hours to process. Routine refill requests will not be honored if the patient has not been evaluated by their physician of record within the past 12 months. However, urgent refill requests will be honored with the understanding that the patient must be evaluated by their physician before another refill is required.

Acceptance of the Medical Services Financial Agreement

I have read and understand the Medical Services Financial Agreement above and all questions that I have concerning this agreement have been answered to my satisfaction.

______________________________ ____________________

Printed Name of Patient Date

____

Signature of Patient, Parent or Legal Guardian

2305 Central Park Blvd. * Bedford, TX 76022 * (817) 571-6622 phone * (817) 868-1962 fax

Mid-Cities Allergy & Asthma Clinic

Health Questionnaire

Name: ______________________________ Date: ______________
Age: ________ Date of Birth: ______________ Gender: ☐ Male ☐ Female
Primary Care Physician: ______________________________ Tel: ______________
Referring Physician: ______________________________ Tel: ______________
How did you hear about our practice? ☐ Physician ☐ Family or Friend ☐ Insurance ☐ Internet ☐ Phone Book ☐ Ad ☐ Other: ______________

Briefly describe the reason for your visit today: ______________________________

____

____

Current Medications:

Allergy/Asthma: (Name/Dose/Frequency)

All Others: (Name/Dose/Frequency)

Medication Allergies:
Med Name: ______________ Reaction: ______________
Med Name: ______________ Reaction: ______________
Med Name: ______________ Reaction: ______________

Previous allergy testing: ☐ No ☐ Yes If Yes, when? ______________ Results: ______________
Previous allergy shots: ☐ No ☐ Yes If Yes, when? ______________ Helpful? ______________

Environmental History: Do you live in a ☐ House ☐ Apartment ☐ Dorm ☐ Trailer ☐ Other______________
Carpet: ☐ Yes ☐ No
Pets: ☐ Dogs How long? ______________ ☐ Cats How long? ______________
☐ Other animals: ______________
Type of pillow: ☐ Feather/Down ☐ Synthetic ☐ Other ______________
Dust covers? ☐ No ☐ Yes If yes, covers for: ☐ pillows ☐ mattress ☐ box spring

Social History: Do you currently smoke? ☐ No ☐ Yes If yes, how long? ______________ Packs per day ________
Are you a former smoker? ☐ No ☐ Yes If yes, how long? ______________ Packs per day ________
When did you quit? ______________
Are there smokers in the household? ☐ No ☐ Yes If yes, who? ______________
Occupation: ______________________________
If the patient is a child, does he/she attend daycare? ☐ No ☐ Yes ☐ Other ______________

Mid-Cities Allergy & Asthma Clinic

Name: ______________________________ Date: ______________

Past Medical History: Do you have a history of (please check all that apply): ☐ High Blood Pressure ☐ Diabetes
☐ Acid Reflux ☐ Thyroid disease ☐ Chronic Bronchitis ☐ Migraines ☐ Glaucoma
☐ Coronary Artery Disease/Congestive Heart Failure ☐ Immunodeficiency
List other medical conditions: ______________________________
____
____
____
____

Past Surgical History: Sinus Surgery ☐ No ☐ Yes when ________ Ear Tubes ☐ No ☐ Yes when________
Tonsillectomy ☐ No ☐ Yes when ________ Adenoidectomy ☐ No ☐ Yes when ________
Other Surgeries: ______________________________
____
____

Review of Systems: Please **circle** any signs or symptoms you are **currently** experiencing:

Constitutional:	Fatigue	Night Sweats	Chills	Fevers	
Eyes:	Pain	Glaucoma	Cataracts	Strabismus	Dry
Ears:	Pain	Vertigo	Infections	Ringing	Loss of hearing
Nose:	Nosebleeds	Deviated Septum	Ulcers	Polyps	Loss of smell
Throat:	Pain	Frequent clearing	Thrush		
Respiratory:	Wheeze	Cough	Tight chest	Shortness of breath	
Cardiovascular:	Chest pain	Palpitations	Slow/fast heart rate		
Gastrointestinal:	Heartburn	Vomiting	Diarrhea	Reflux	Trouble swallowing
Genitourinary:	Blood in urine	Kidney stones	Discharge	Urine infections	
Skin:	Blistering	Dry	Itch	Hives	Swelling
Neurological:	Numbness	Seizures	Migraines		
Hematology:	Easy bruising	Easy bleeding	Swollen lymph nodes		
Endocrine:	Weight gain	Weight loss	Increased thirst	Cold/heat intolerance	
Musculoskeletal:	Stiff/sore joints	Muscle pain	Red/swollen joints		
Psychological:	Anxious	Depressed	Stressed	ADD/ADHD	

Family History:

	Father's Side	Mother's Side	Siblings
Asthma	____________	____________	____________
Hay Fever	____________	____________	____________
Eczema	____________	____________	____________
Hives/Swelling	____________	____________	____________
Migraines	____________	____________	____________
Immunodeficiency	____________	____________	____________
Other	____________	____________	____________