BERNSTEIN ALLERGY GROUP, INC.
FINANCIAL POLICY

Your clear understanding of our financial policy is important to our professional relationship. **Our practice does not participate in all insurance plans. It is the patient's responsibility to determine if we are a covered provider and to understand their benefits and coverage. The patient is responsible for all balances not covered by the insurance plan.**
For your convenience, balances can be paid by cash, check, MasterCard, Visa, Discover or Care Credit.

Self Pay Patients (no insurance coverage) - a pre-payment of $150 is required for all new self-pay patients on the date of service. We also offer a 25% discount if the total balance is paid on the date of service.

Co-pays, Coinsurance and Deductibles - are due at the time of service.

Care Credit - a health care credit card designed to pay for treatment and procedures not covered by insurance. *No interest if paid in full within 6 months (see flyer for details). You can apply on-line or in our office.

Payment Plan - Payment plans should be established with our billing department. If a patient misses two payment plan installments, the account will be sent to an outside collection agency and we reserve the right to dismiss you as our patient.

Workers' Compensation - we will file a claim only with the Ohio Bureau of Worker's Compensation. We will not file any claims related to out-of-state worker's compensation programs.

Returned Check Fees - a fee of $40 will be charged on all checks returned to us for insufficient funds.

No Show Fees - failure to contact our office to cancel your appointment within 24 hours or do not appear for your scheduled appointment, we will charge a fee of $60 for new patient visits and $25 for an established patient visit or testing visit. This fee must be paid before another appointment is scheduled.

Monthly statements for patient balances are mailed at the end of each month for your prompt payment. Any patient balance that remains unpaid after 60 days will be subject to a 2% finance charge. No new appointments will be scheduled until the past due balance is paid in full. Patient balances unpaid after 90 days will require payment in full or a payment plan to be established within 10 days of notice. If a payment or payment plan is not established, the account will be referred to an outside collection agency and we reserve the right to dismiss you as our patient.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY OF THE BERNSTEIN ALLERGY GROUP, INC.

_____ _____

Signature Date

BERNSTEIN ALLERGY GROUP, INC.

PATIENT HIPAA CONSENT FORM

By signing this form, you are granting consent to The Bernstein Allergy Group, Inc. and The Bernstein Clinical Research Center, LLC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at 513-931-0775.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that we already have used or disclosed your protected health information in reliance on your consent.

Print Patient Name: _____

Patient Signature: _____

Date: _____

BERNSTEIN ALLERGY GROUP INC.

Bernstein Allergy Group Allergy & Asthma Questionnaire

Name: _____ Date: ____ / ____ / _____

Date of Birth: ____ / ____ / _____

- ***Do you have or have you had breathing problems (such as asthma, COPD, bronchitis)?***

☐ **No** (*Skip Questions 1-5*) ☐ **Yes** (*Answer Questions 1-5*)

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?

1 ☐ All of the time	**2** ☐ Most of the time	**3** ☐ Some of the time	**4** ☐ A little of the time	**5** ☐ None of the time

2. During the past **4 weeks**, how often have you had shortness of breath?

1 ☐ More than once a day	**2** ☐ Once a day	**3** ☐ 3 to 6 times a week	**4** ☐ Once or twice a week	**5** ☐ Not at all

3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

1 ☐ 4 or more nights a week	**2** ☐ 2 or 3 nights a week	**3** ☐ Once a week	**4** ☐ Once or twice	**5** ☐ Not at all

During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

1 ☐ 3 or more times per day	**2** ☐ 1 or 2 times per day	**3** ☐ 2 or 3 times per week	**4** ☐ Once a week or less	**5** ☐ Not at all

5. How would you rate your **asthma** control during the **past 4 weeks**?

1 ☐ Not controlled at all	**2** ☐ Poorly controlled	**3** ☐ Somewhat controlled	**4** ☐ Well controlled	**5** ☐ Completely controlled

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6. In the past **4 weeks**, have you had **allergy symptoms**? ☐ No ☐ Yes (Check all that apply below)

☐ Nasal congestion ☐ Runny nose ☐ Post-nasal drip ☐ Sneezing ☐ Cough
☐ Eye itch ☐ Eye watering ☐ Headache ☐ Ear symptoms ☐ Other: _____

7. For the past **4 weeks**, please rate the overall level of **control** of your **allergy symptoms** on average:

WORST 1 2 3 4 5 6 7 8 9 10 **BEST**

☹ ☺

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*8. In the past **4 weeks**, have you had any of the following symptoms?

☐ **No** ☐ **Yes** (*Check all that apply below*)

☐ Weight change	☐ Fever	☐ Frequent urination	☐ Urinary infection
☐ Itching	☐ Rash	☐ Muscle weakness	☐ Joint pain
☐ Headache	☐ Change in vision	☐ Easy bruising	☐ Blood transfusion
☐ Change in hearing	☐ Dental problems	☐ Heat/cold intolerance	☐ Change in appetite
☐ Change in smell	☐ Hoarseness	☐ Fainting	☐ Seizures
☐ Cough	☐ Difficulty breathing	☐ Anxiety	☐ Depression
☐ Chest pain	☐ Leg swelling	☐ Joint Stiffness	☐ Seasonal Allergies
☐ Nausea/vomiting	☐ Diarrhea		

Patient's Signature: _____ Date: ____ / ____ / _____

Provider's Initials: _____ Date: ____ / ____ / _____

Name:_____ Date of Birth: ____ / ____ / _____ Date: ____ / ____ / _____

Bernstein Allergy Group Nursing Orders and Notes

- Office Use Only -

Orders: *Room:

- ☐ Skin Prick Testing (☐ Complete Aeroallergens / ☐ Select Aeroallergens / ☐ Select Foods)
- ☐ Intracutaneous Testing (Select Aeroallergens)
- ☐ Pulmonary Function Testing (☐ Baseline / ☐ Pre/Post Bronchodilator / ☐ Methacholine Challenge)
- ☐ Exhaled Nitric Oxide
- ☐ Nasal Sample for Eosinophils
- ☐ Patch Testing:
- ☐ Challenge Procedure:
- ☐ Lab Tests:
- ☐ Other:

Education:

- ☐ Diagnosed Disease:
- ☐ Avoidance:
- ☐ Medication:
- ☐ Inhaler Technique:
- ☐ Asthma Action Plan:

Samples:

Notes:

Nurse's Signature: _____ Date: ____ / ____ / _____