UofL Physicians

GENERAL CONSENT FORM

PATIENT NAME: _____ Date of Birth: _____

Payment. I authorize University of Louisville Physicians, Inc. (UofL Physicians) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that UofL Physicians will direct payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. Patient Initials: _____

Consent for Treatment. I consent for UofL Physicians to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the doctor, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms, or conditions. Patient Initials: _____

Electronic Prescription. I understand UofL Physicians utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient. Patient Initials: _____

Cell Phone Calls. As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Involvement of Others in Care. I authorize UofL Physicians to provide and discuss my/the patient's care and medical needs with the following persons:

Name	Relationship	Phone

Patient Rights and Responsibilities

I acknowledge receipt of the Patient Rights and Responsibilities_____ Declined_____

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices_____ Declined_____

Minor Patient Photograph

I consent for UofL Physicians to photograph the patient for identification purposes only_____ Declined_____

_____ _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature Date

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____

UofL Pediatrics

Practice Financial Policy

UofL Pediatrics

Financial Policy

UofL Pediatrics participates with most major insurance companies and will file all charges incurred on your behalf. In order to file promptly and accurately, an insurance card must be provided. Your insurance policy is a contract between you and your insurance carrier. Not all services are a covered benefit in all contracts. Each guarantor is responsible for knowing their plan's benefit package, co-payment, co-insurance, deductible, non-covered services and restrictions. You must also know your insurance company's provision for office visits, well child visits, immunizations and annual routine exams including school, camp or sports physicals.

Terms of Payment – Payment is due at the time services are rendered unless other arrangements have been made in advance. This includes co-payments, co-insurances, deductibles and non-covered services per your contractual obligation with your insurance company. This policy is in effect regardless of who brings the child in for the appointment, even if they are not the account guarantor.

Co-Payments – UofL Pediatrics is contractually obligated by your insurance company to collect your co-payment at the time of each visit. We are contractually prohibited from writing off patient responsibility amounts.

Forms of Payment – UofL Pediatrics accepts cash, check, money order, VISA, MasterCard, Discover, and debit cards. If necessary, we are eager to arrange payment plans.

Billing Process – Primary and secondary insurances are filed by our office on your behalf. Billing statements are mailed out monthly and are due in full upon receipt. Once you receive a statement, the balance is your responsibility. Please pay promptly

Returned Checks – There will be a $35.00 fee charged for all checks returned by your bank for any reason. After two returned checks, you will be required to pay with cash or credit card for future service.

Form Fee – There will be a $10.00 - $25.00 fee charged for specialized forms that are filled out by the doctor (FMLA forms, camp forms, school physical forms, insurance forms, disability determination forms, medical necessity forms, pre-op forms, etc).

Missed Appointments – Your appointment time is reserved especially for you. Please be respectful. Please notify the Practice 48 hours in advance for a cancellation.

Collections – Once routine billing and collection practices have failed, unpaid accounts will be forwarded to the collections agency currently used by UofL Pediatrics.

Overpayment – In the event of an overpayment on the account by the insurance carrier or the patient, a refund will be issued immediately. Alternately, this can be used as credit on your account if you wish.

Financial/Billing Questions – All questions or concerns regarding charges, billing, and collections should be directed to the Central Billing Office.

I have read and understand the Financial Policy of UofL Pediatrics.

_____ _____

Patient Representative Signature **Date**

Patient Name _____ **DOB** _____

UofL Physicians Allergy and Immunology

210 East Gray St Suite 802
Louisville, KY 40202
Phone: 502-588-2349 Fax: 502-588-9535

Patient Name:_____ Date of Birth:_____ Age:_____ Today's Date:_____
Parent's Name *(if a child)*:_____ Home phone:_____ Email:_____
Primary Care Physician:_____ Referring Physician:_____
CC: Briefly describe the main reasons for coming to an allergy/asthma specialist:_____
_____
_____
_____

HPI/ROS:

"Check" if the patient is bothered by the following symptoms:

___ Nasal/Sinus congestion
___ Runny nose
___ Itchy nose
___ Post nasal drainage
___ Bouts of sneezing
___ Sore throat
___ Hoarseness
___ Throat clearing

___ Itchy eyes
___ Red eyes
___ Dry eyes
___ Headaches
___ Sinus pain/pressure
___ Frequent sinus infections
___ Loss of taste or smell
___ Snoring / Sleep problems

___ Shortness of breath
___ Wheezing
___ Chest tightness
___ Frequent bronchitis
___ History of pneumonia

___ Cough
___ Cough worse at night
___ Cough with exertion
___ Coughing in spasms
___ Cough producing mucus

___ Diagnosed with **asthma**? (*if yes-please answer the following*):
Diagnosed when?: _____
# of ER visits for asthma: _____ Last ER visit: _____
# of hospitalizations for asthma: _____ Last Hosp: _____
Last course of oral steroid (prednisone): _____
Do you use a spacer (Vortex, Aerochamber?): _____
Any disturbance in sleep due to asthma?: _____
How many days a week do you have cough or wheeze?: _____
How many nights a week do you have cough or wheeze?: _____
How many days a week do you use your albuterol?_____
How does asthma limit your physical or social activity?
□ None □ Minor limitation □ Some limitation □ Extremely limited
How well is your asthma controlled?
□ Not controlled □ Poorly □ Somewhat □ Well □ Completely controlled

___ Frequent vomiting ___ Frequent diarrhea ___ Painful swallowing
___ Abdominal pain ___ Weight loss ___ Difficulty swallowing
___ Heartburn (reflux) ___ Nausea ___ Food getting stuck

___ Dry skin ___ Eczema ___ Itchy skin
___ Hives ___ Sores ___ Swelling

Check below if any of the following causes symptoms to worsen:
___ Cats ___ Grass ___ Fumes/Odors ___ Colds
___ Dogs ___ House Dust ___ Medication ___ Occupational
___ Horse ___ Smoke ___ Meals
___ Dry Air ___ Exercise ___ Menses
___ Cold Air __ Change in weather ___ Sudden temperature changes
Check worse seasons: ___ Spring ___ Summer ___ Fall ___ Winter
___ Year-round

PROVIDER'S COMMENTS/NOTES

UL Physicians

Allergy and Immunology

REVIEW OF SYSTEMS: (Check if you currently or routinely experience any of the following):
Constitutional: □ night sweats □ weight loss/gain □ fatigue □ fever □ chills □ decreased appetite
Cardiovascular: □ palpitations □ murmur □ heart pain □ breathing difficulty when lying flat
Genitourinary: □ blood in urine □ incontinence □ inability to urinate □ frequent or painful urination
Musculoskeletal: □ muscle pain □ muscle weakness □ joint pain/swelling
Neurologic: □ double vision □ blackouts □ numbness □ tremor □ headaches
Endocrine: □ voice change □ hair change □ increased thirst □ heat or cold intolerance
Hematologic: □ easy bruising □ prolonged bleeding □ swollen lymph nodes
Psychiatric: □ depression □ anxiety □ nervousness □ hallucinations

PAST MEDICAL HISTORY:
Immunizations up to date? _____ Problems at birth? _____
Previous allergy testing? _____ When? _____ By whom? _____
Are you currently on allergy shots? _____ Since when? _____ How long? _____
Previous allergy shots?_____ When?_____ By whom? _____
Allergies/Reactions to medications? (describe)
_____
Allergies/Reactions to foods? (describe)
_____
Reactions to insect stings? (describe)
_____
List other medical problems:
_____
_____
List previous hospitalizations & surgeries:
_____
_____
List all current medications:
_____
_____
List medications you have taken previously for allergy/asthma symptoms:
(i.e. antihistamines, decongestants, nasal sprays, inhalers, antibiotics)
_____
_____

FAMILY MEDICAL HISTORY: (Circle if there is a family history of the following:)
Allergies/hay fever Sinus problems Asthma Bronchitis/emphysema Immunodeficiency
Cystic Fibrosis Eczema Autoimmune disease Childhood death Swelling
Other major diseases *(describe):*
_____

SOCIAL ENVIROMENTAL HISTORY:
Occupation:_____
Any irritant/allergic/chemical occupational exposures? *(describe)*
_____
Does the patient smoke? □ Yes □ No Previous smoker? □ Yes □ No # of years? _____
# of packs per day _____ Any smokers in the home? □ Yes □ No Who?_____
Indoor pets? ___ cat ___ dog ___ bird ___ other Air freshener use? _____
List any other smoke or pet exposure: (*grandparents, babysitter, friends*)
_____
(If child) Attends day care? □ Yes □ No # of days attended per week:_____
_____
(If child) Does child live with both parents? □ Yes □ No *If not*, describe visitation:_____
_____
Check conditions that apply to your home:
Dwelling type: □ House □ Apartment □Trailer □Other:_____
Foundation: □Basement □Crawl space is it damp? □ Yes □ No
Flooring: □Area rugs □Wall to wall carpet □Tile □ Hardwood
Heating: □Electric □Kerosene □Gas □Wood
Air conditioning: □ Yes □ No type? □Central □Window
Humidifier/Vaporizer: □ Yes □No type? □Central □Bedroom
Mattress type: □Innerspring □Foam □Waterbed
Pillow type: □Polyester □Foam □Feather
Allergy covers on mattress/pillows? □ Yes □ No
Pests: □cockroach □ mice/rats □ bedbugs
Do you use air fresheners? □ Yes □ No

PROVIDER'S COMMENTS/NOTES

□ ROS: Reviewed all systems, all normal unless marked.

I have personally examined the patient, evaluated, reviewed and verified the details of the Resident's notes and have been involved in the critical decisions for the plan of care as detailed above.

_____ Attending Signature

_____ Resident Signature

_____ Nurse/MA Signature