BAKER
ALLERGY · ASTHMA
DERMATOLOGY

Before your first Allergy/Asthma appointment:

- Please verify that Baker Allergy, Asthma, and Dermatology is in network with your insurance plan before your appointment date.
- If needed, obtain a referral from your primary care physician.

What You Need to Know for Your Appointment:

- In order to do allergy testing it is important to stay off of antihistamines for three days before your appointment. Antihistamines will block the results of the allergy testing. Please note that many cough and cold medicines also contain antihistamines- be sure to read labels carefully! If you are unsure about a medication, feel free to call and ask us. Any medications, except those containing antihistamines, can be taken as usual.
- Bring in your insurance card or a printout of your card, if you have an electronic version, to your appointment.
- Fill out the New Patient Packet and bring to the clinic for your appointment. Allergy testing will be done on the back and arms. Please wear comfortable clothing that allows easy access to these areas. It can be chilly during the testing, so bring a sweater to wear while you are waiting for your results.
- Please allow two hours for this first appointment- we will gather your history, do the testing and send you home with your results all in this first appointment.
- If you have any questions, please give us a call at **503-636-9011**.
- We are located at:
  9495 SW Locust Street, Suite A
  Portland, OR 97223

Baker Allergy, Asthma & Dermatology
New Patient Questionnaire

Name_____ Preferred Name_____
Date_____ Age_____ Male/Female

What is your goal for today's visit?

What problems do you want to discuss today?

1.

2.

3.

Please list ALL of your Current Medications, including Vitamins & Supplements:

Medication Name	Dose	Frequency	Reason/Condition

Do you have any medication allergies? Yes/No (Please list below)

_____

_____

Did you get a Flu Shot this year? Yes/No Have you ever had a Pneumonia shot? Yes/No

Have you ever had any of the following? If yes, please circle:

Asthma	Eczema	Immune Disorder	Diabetes
Seasonal Allergies	Hives	Acid Reflux	Glaucoma
Year Round Allergies	Angioedema	Stomach Problems	Psoriasis
Food Allergies	Sinusitis	Heart Problems	Herpes
Food Intolerance	Bee Sting Allergy	High Blood Pressure	Cancer

Please list ALL of the surgical procedures you have had and the approximate year:

_____

_____

_____

Which best describes your living situation? (Please circle) Single/Married/Divorced
With Parents/Split-time with Parents/Independent/Roommates/Other

Preferred Pharmacy _____ Location_____
Phone _____ Fax_____

Primary Care Doctor _____ Location_____
Phone _____ Fax_____

Referring Physician _____ Location_____
Phone _____ Fax_____

BAKER ALLERGY, ASTHMA & DERMATOLOGY

Be sure to complete both sides

ACCOUNT_____ **DATE**_____ **NEW / UPDATED**

DEMOGRAPHICS

PATIENT'S FULL NAME_____ BIRTHDATE:_____ SEX: M / F

ADDRESS_____

CITY, STATE, ZIP _____

OCCUPATION/EMPLOYER _____ WORK PHONE _____

HOME PHONE _____ CELL PHONE _____

SPOUSE/RESPONSIBLE PARTY _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____ ADDRESS (if different than above)_____

HOME PHONE _____ CELL PHONE _____ OCCUPATION/EMPLOYER _____

*IF PATIENT IS A **MINOR**:*

FULL NAME OF MOTHER: _____ FULL NAME OF FATHER: _____

*IF PATIENT IS **OVER 18**:*

I authorize _____ (relationship:_____) to have access to my records / billing information (circle all that apply).

INSURANCE

PRIMARY INS CO_____ SECONDARY INS CO_____

BILLING ADDRESS _____ BILLING ADDRESS _____

SUBSCRIBER'S NAME_____ SUBSCRIBER'S NAME_____

SUBSCRIBER'S DATE OF BIRTH_____ SUBSCRIBER'S DATE OF BIRTH_____

ID# _____ ID# _____

GROUP #_____ EFFECTIVE DATE_____ GROUP #_____ EFFECTIVE DATE_____

PRIMARY CARE DOCTOR _____ PHONE #_____

Were you referred to us by a patient or known acquaintance of any staff members? Y / N Name _____

Have you or any of your family members ever been seen at our clinic? Y / N Name(s) _____

AUTHORIZATION

CONTACT AUTHORIZATION: I hereby authorize Baker Allergy, Asthma & Dermatology to leave a voicemail regarding visits, and any results needing communicated at the phone number provided below.

Phone: _____

CONTACT AUTHORIZATION: I hereby authorize Baker Allergy, Asthma & Dermatology to send an email regarding visits, and any results needing communicated at the email address provided below.

Email:_____Signature authorizing the above statement(s):_____

(if patient is a minor, signed by parent or legal guardian)

OFFICE USE ONLY

Updated: Date/Initial _____ Date/Initial _____ Date/Initial _____

JAMES W. BAKER, MD, LLC
DBA: BAKER ALLERGY, ASTHMA & DERMATOLOGY

PATIENTS RESPONSIBILITY FOR PAYMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our business manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Baker Allergy, Asthma & Dermatology will submit charges for medical treatment to the patient's insurance company and where applicable, to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.

Baker Allergy, Asthma & Dermatology does not verify in advance the patient's insurance. Patients should contact their insurance companies directly for any coverage questions they may have. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay.

If the patient participates in an Oregon Health Plan program, the patient will be responsible for notifying the office at the time of service. If the patient participates in Washington DSHS, the patient will be responsible for all services. Baker Allergy, Asthma & Dermatology does not accept Washington DSHS.

Baker Allergy, Asthma & Dermatology 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 even if there is a pending lawsuit.

If the patient participates in a plan that requires co-payment, the patient must pay the co-payment at the time of the appointment.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at Baker Allergy, Asthma & Dermatology for medical care and treatment. I agree to pay all medical expenses within 90 days of the date those expenses were incurred.

Patient Responsibility (Disclaimer)

I understand that my insurance plan may require a referral from my Primary Care Physician in order to cover the visits to a Specialty Physician. If Baker Allergy, Asthma & Dermatology at this time has not received verification that a referral was obtained for services, and, if my insurance company denies payment, I agree that I will be financially responsible for any and all charges incurred (including lab and x-ray).

I hereby assign to Baker Allergy, Asthma & Dermatology any and all insurance benefits due me to the fullest extent of my financial obligation. I authorize them and the physician to release to the insurance company any information acquired in the course of my examination and treatment.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Baker Allergy, Asthma & Dermatology to release to my insurance company any information acquired in the course of my examination or treatment. I also agree to full responsibility for all expenses incurred by or on account of myself or this patient and hereby assign to Baker Allergy, Asthma & Dermatology any and all insurance benefits due to the fullest extent of my financial obligation to said office.

Patient Signature (Parent or Guardian if patient is a minor)	Date	Patient Printed Name

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have access to a copy of the

BAKER ALLERGY, ASTHMA & DERMATOLOGY

Notice of Privacy Practices

By signing below, I agree that I have access to a copy of the Notice of Privacy Practices through the website and through hard copies conveniently located in the lobby of the clinic.

_____ _____
Patient Signature Date

_____
Print Patient Name

-OR-

_____ _____
Parent, Guardian, Responsible Party, Legal Representative Signature Date

_____
Description of Representative's Authority

NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES YOUR REFERRAL RIGHTS WHEN YOUR HEALTH CARE PROVIDER REFERS YOU TO ANOTHER PROVIDER OR FACILITY FOR ADDITIONAL TESTING OR HEALTH CARE SERVICES.

In accordance with Oregon law, when you are referred for care outside of our clinic, we at Baker Allergy, Asthma & Dermatology, are required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law says (ORS 441.098):

- A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.
- A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient.
- The oral or written notice of patient choice shall clearly inform the patient:
  (a) That when referred, a patient has a choice about where to receive services; and
  (b) Where the patient can access more information about patient choice.
- The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;
- If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.
- **By signing below, I acknowledge that I have read and understand my referral rights as outlined above.**

_____ _____
Patient Signature Date

_____
Print Patient Name

-OR-

_____ _____
Parent, Guardian, Responsible Party, Legal Representative Signature Date

_____
Description of Representative's Authority