ENT | LAWRENCE OTOLARYNGOLOGY
HEAD & NECK SPECIALISTS

PLEASE FILL OUT ALL PAGES **PRIOR** TO ARRIVING AT YOUR APPOINMENT.

Your initial allergy evaluation is scheduled
with Warren E. Frick, MD in our Allergy Suite.

Address:
1112 W 6th Street **Suite 210** Lawrence, KS 66044
***Please use King Pharmacy entrance to access Suite 210*

It is your responsibility to contact your insurance company and find out if we are "In Network" with your specific plan. If you have questions about out of pocket costs, deductibles or charges, please call your insurance PRIOR to your apppintment.

Your co-pay is due at the time of service. If you do not have insurance, we require full payment. We cannot file your insurance without your current insurance card so please bring your card and any necessary referrals that are required by your carrier. Without your insurance card and referral, your appointment may have to be rescheduled.

REFERRALS: It is your responsibility to obtain a referral from your primary card physician to be seen in our office *if your insurance requires it*. We require all Tricare, VA and Haskell referrals to be sent to our office prior to your appointment.

You may not be tested on your first visit. Please allow ~2 hours for your initial appointment. If you are not able to keep this appointment, please call our office at least 48 hours in advance.

THANK YOU FOR YOUR CONSIDERATION. WE LOOK FORWARD TO MEETING YOU!

Lawrence Otolaryngology Associates
ASTHMA & ALLERGY DEPARTMENT
Warren E. Frick, M.D.
Ph: 785-841-1107 | www.lawoto.com | Fx: 785-841-1173

Lawrence Otolaryngology Associates, LLC Chart #_____

Patient Registration Information

All information must be filled in prior to appointment.

PATIENT INFORMATION

First Name	Middle Initial	Last Name	Preferred Name (if different)	Date of Birth

Street Address/apt#	City	State	Zip code

Home Phone Number	Work Phone Number	Cell Phone Number	SSN

Sex M F	Marital Status	Preferred Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown

Race (circle): African American Asian White/ Caucasian Native American Other

Optional: Additional Gender Identity Info:

Patient Current Employer/ School (circle): Student Minor Retired Disabled Homemaker Employed Not Employed Full-time Part-time

Employer/School/ Daycare Name and Job title: Phone:

GUARANTOR INFORMATION ☐ **Check box if the responsible party is the same as above.**

First Name	Last Name	Date Of Birth	Sex

Street Address	City	State	Zip code

SSN	Employer Name and Job Title:	Work Phone Number
Home Phone #	Email address	Cell phone #

EMERGENCY CONTACT INFORMATION: If Patient is a Minor list both parents. *Please list two separate people with 2 different phone numbers.*

Emergency Contact Name	Home Phone:
Relationship to Patient If parent to minor, please list SSN:	Work Phone:
Employer Name:	Cell Phone:

** I authorize Lawrence Otolaryngology Associates to disclose health information to the person listed above. ☐ Yes ☐ No

Secondary Contact or Next of Kin Name	Home Phone:
Relationship to Patient If parent to minor, please list SSN:	Work Phone:
Employer Name:	Cell Phone:

** I authorize Lawrence Otolaryngology Associates to disclose health information to the person listed above. ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Name	ID/Certificate Number	Group ID/Number	
Policy Holder (Subscriber) Name & Address, if different than Patient:	Relation To Patient	Subscriber DOB	Subscriber Sex

I HAVE SECONDARY INSURANCE: YES / NO **I HAVE TERTIARY INSURANCE: YES / NO**

Secondary Insurance Name	ID/Certificate Number	Group ID/Number	
Policy Holder (Subscriber) Name & Address, if different than Patient:	Relation To Patient	Subscriber DOB	Subscriber Sex

Medicare Patients: Is Patient in a skilled nursing facility? YES / NO If YES, list facility name:

REFERRING PHYSICIAN INFORMATION

Referring Provider Name:

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lawrence Otolaryngology Associates, LLC. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I acknowledge financial responsibility for balance due and, in the event of default, agree to pay all collection costs. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits and agree a photocopy of this agreement shall be valid as the original. I understand that no guarantees have been made to me regarding the outcome of this care.

I acknowledge I have been offered LOA notice of privacy practices. I understand that Lawrence Otolaryngology Associates, LLC has made every effort to ensure the privacy of our internet system but cannot guarantee that internet communications are completely confidential. I acknowledge LOA will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this communication waiver at any time. I understand that I may revoke my consent to disclose health information at any time in writing. Any revocation or change will not apply to past communications. I understand this authorization will remain in effect for one year from the date signed unless I specify a date here: _____. I understand courtesy appointment reminder calls, text messages or emails and other important communication may be placed using a pre-recorded message and consent to receiving such communication.

I confirm that I have read the above information and it is current and true.

Signature: _____ Date: _____

Chart #_____

Patient Name: _____

EMAIL REQUEST

With changes that have been made by CMS, a part of the US Dept. of Health and Human Services, we are required to offer our patients access to a patient portal and the ability to electronically communicate with our physicians/nurses securely. For our office to meet this requirement, we must collect e-mail addresses from our patients. Please know that:

1. Your e-mail address will be kept confidential and will not be used for any other purpose than those of our office.
2. We do not use e-mail to send health information unless requested by the patient (see below).
3. You will receive an invitation to join our patient portal and be given the opportunity to provide a review of your physician but are not required to do either.
4. Parents/guardians may use their e-mail address for their children.

****Please print your email address clearly**: _____

At Lawrence Otolaryngology we understand that email allows a quick, convenient way to correspond with our patients. However, in order for us to use email as a way of communication, we will need your written permission to do so. Please know that your email is not shared with anyone other than our physicians and immediate staff who schedules appointments or surgeries, sends out statements, or sends other patient information. We WILL NOT send you emails containing personal information unless you specifically request that we do so.

Disclaimer: You need to be aware that messages sent via email are routed and stored on multiple servers, then pass through the Internet and are sent to your email. If you have given us your work email, remember that your employer has the legal right to review the email.

☐ **YES**, I approve Lawrence Otolaryngology to send emails containing personal health information. Lawrence Otolaryngology will send emails containing personal health information ONLY upon receiving a phone call or email requesting such information.

☐ **NO**, I do not approve Lawrence Otolaryngology to send emails containing personal health information

Patient/Guardian Signature: _____ **Date**: _____

FINANCIAL AGREEEMENT **Chart # _____**

Read through this information carefully

Thank you for choosing our practice! Our objective is to provide you with the highest quality health care in the most cost-effective manner. We recognize the importance of having a clear financial policy for everyone's benefit, though we also understand that insurance can be confusing. Our goal is to prevent any misunderstandings or concerns regarding financial matters so that we can dedicate our efforts to delivering excellent healthcare services to our patients. We will gladly do our best to answer any questions relating to your insurance.

Insurance: Health Insurance cards must be given to the Receptionist at time of service. If you do not have a physical card, you will need to bring in a copy of your card. We participate in most insurance plans and will fill insurance claims on your behalf. Each plan has different benefits and financial obligations; knowing your insurance benefits is your responsibility. Remember that your insurance contract is between you and your insurer. Not all insurance policies cover all services. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, $100 is due for each visit until you can verify your coverage. Please contact your insurance company with any questions you may have regarding your coverage. It is your responsibility to furnish our office with current, accurate information at the time services are rendered and/or notify us in a timely manner of any changes in coverage which may affect the payment of services already rendered.

- **Non-covered services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable by Medicare or other insurers. Some insurance companies arbitrarily select certain services they will not cover (i.e., x-rays, labs, hearing tests, Epley maneuver, elective procedures, and pre-existing conditions). You will be responsible for the full charges of these services.

- **Co-Pay, Co-Insurance and Deductibles: Payment is expected at time of service for co-pays, co-insurance and deductibles that have not been met, as well as any previous balances due.** You can locate your co-pay on your insurance card or call your insurance company to find out what your co-pay, co-insurance and deductible for a specialist will be. Co-pays, co-insurance and deductibles are dictated by your insurance plan and must be paid at the time of your appointment.

- **High Deductible Health Plan (HDHP):** is a health insurance plan that has a high minimum deductible, which does not cover the initial costs or all of the costs of medical expenses. The deductible requires the patient to pay the first portion of a medical expense before the insurance coverage kicks in. **Patients that have a high deductible health plan of $1000.00 or more will need to be prepared to pay for their office visit and any testing done during their visit before they leave the office.** You may visit with our billing office about payment plans if needed.

- **Insurance Authorizations:** If your visit requires authorization, it is your responsibility to have your PCP send an authorization request to your insurance company prior to your appointment. If the authorization is not obtained, the appointment will be cancelled or you will be responsible for the full cost of the visit.

Self-Pay Patients: Self pay patients are patients that have no insurance, do not have a copy of their insurance card with them at the time of service or have an insurance that we are not in network with. Self pay patients are required to pay for their visits at the time of service. Patients are required to pay a deposit of $100.00 upon checking in and pay the remaining difference, if applicable, after their visit with the provider.

College Students: if you have United Health Care student insurance you may have some "policy exclusions" depending on what you are coming into the office for. Please call your insurance company to find out if your visit will be covered.

Surgery and Procedures: Our office will verify insurance eligibility will estimate out of pocket costs for scheduled surgeries and procedures. Please note this is only an estimate based on the information your insurance company provides to us at the time of verification. You may owe more or less once insurance processes your claim. Not all pre-op or post-op appointments are included in this estimate. We encourage patients to also verify their own benefits. Our clinic will obtain the necessary authorizations prior to surgery; however, prior authorization is not guarantee of payment. You are responsible for all charges not paid by your insurance company.

Social Security Numbers: We are required to have the patient's SSN number in order to schedule any surgeries or procedures at LMH, LSC or AdventHealth Ottawa. Not having this information will delay the scheduling process.

Patient balances and payment arrangements: Patients who are unable to pay in full at the end of their visit will need to talk with our billing department for payment arrangements. Balances that are billed to the patient via payment arrangements are expected to be paid in full within 30 days of the mailed statement. Unpaid accounts may be sent to an outside collection service if financial obligations are not met.

Children and Adolescents: We will not see your child when brought in by someone other than a mother or father unless the adult bringing your child in has a written note signed by you authorizing treatment and financial responsibility. Guardians must bring in guardianship paperwork at first appointment to be scanned into your child's chart.

Divorce decrees: This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays, co-insurance and deductibles are my responsibility.

_____ _____ _____

Print Patient Name Signature of Patient or Parent/ Guardian Date

Patient Name: _____ Chart #_____

OFFICE PROCEDURES and ADDITIONAL FEES

During your office visit your provider may determine that additional procedures must be performed in addition to the specialty examination for asthma and allergy to provide appropriate medical care.

Following insurance guidelines, these procedures must be billed separately from the office visit. Most of these procedures are considered to be "covered" procedures by most insurance plans, but they could result in increased out of pocket expense for you as well depending on your individual insurance coverage. Depending on your deductible, part of the allowable fee for these services may be your responsibility. This may be in addition to your copay.

Copays are required at the time of service. If there is a balance after insurance processes your claim, we will send you a statement. Please be aware that any unmet deductible can significantly contribute to your out-of-pocket expense. It is your responsibility to check with insurance regarding coverage.

The fee for the initial office visit itself will be ~$220-$320. Skin testing could be an additional $400-800. This is an estimate that could be higher, depending on the number of tests that are done. If you do not have insurance, we require full payment at the time of service. Arrangements must be made in advance if payment cannot be made in full on the day of the appointment.

If you have questions about your coverage we encourage you to call your insurance company to see if the following items will be covered and if there will be any out of pocket amount owed by you: Percutaneous (prick) skin tests, Intracutaneous (ID) skin tests, spirometry, brochospasm study, allergy shot vials/ extracts & allergy injections.

NOTIFICATION OF NO-SHOW POLICY

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy.

We understand that sometimes a patient is unable to attend a scheduled appointment due to unforeseen circumstances; however, in order to build a trusting relationship between you and your provider it is important that appointments are kept and your care is consistent. We require a 24-hour notice in the event of a cancellation. When a patient does not show for an appointment, three people are affected: the patient because they do not receive treatment; the provider who now has a space in their schedule since the time was reserved for that patient; and another patient who could have been scheduled for treatment if there had been adequate notice. As a courtesy, you will receive an appointment reminder via phone/text/email two (2) business days ahead of your appointment.

Should you fail to come to an appointment and/or do not give proper notice, your visit will be counted as a "no show". After two (2) no show visits, you may receive a warning letter. After three (3) no show visits, our office reserves the right to decline rescheduling. We will then make a recommendation of alternative providers you may establish care with and will forward your records to the provider of your choice. Please be aware that any no show appointments occurring prior to the signature of this document may count towards your limit.

Please note: We require a 48-hour cancellation notice for patients who are scheduled for a procedure or surgery. A 50% deposit paid toward the procedure or surgery is non-refundable if cancelled without proper notice.

I have read and understood policy and billing information as described above.

_____ _____

Print Patient Name (or Parent/Guardian if patient is under 18 yrs) **Patient Date of Birth**

X_____ _____

Signature of Patient or Parent/Guardian **Date**

Chart # _____

ALLERGY QUESTIONNAIRE

Thank you for completing this questionnaire
before coming for your appointment with Dr. Frick.

Patient Name: _____ **Age:** _____ **Date:** _____
Gender: _____ Preferred pronouns: _____

Is the patient a student? Yes ☐ No ☐ If so, where?_____
If so, what grade or year? _____
If in college, what major? _____
Occupation, if applicable _____

If the patient has a primary care doctor, please provide name: _____

Patient was referred to Dr. Frick by:

- ☐ Primary care doctor
- ☐ Doctor other than primary doctor: _____
- ☐ Friend/family
- ☐ Provider list from insurance company
- ☐ No one
- ☐ other _____

Did you hear about our office from any of these sources?

- ☐ our clinic Facebook page
- ☐ our clinic web page
- ☐ other website
- ☐ word of mouth

Name of person completing this form: _____
Relationship to patient: _____

Please try to tell us in 5 words or less what has brought you to see Dr. Frick:

_____

PLEASE COMPLETE THE FOLLOWING SECTIONS DEPENDING ON YOUR CONCERNS:

- Sections 2, 4, 5 and 6 for drug allergy, insect sting allergy, rash, latex allergy.
- Sections 2, 4, 5, 6 and 7 for food allergy.
- All sections for asthma, hay fever, nasal/ocular allergies, sinus, other.

1. HISTORY

Duration of problem: _____ ❑hrs ❑days ❑wks ❑months ❑years
Season(s) affected: ❑winter ❑spring ❑summer ❑fall ❑n/a
Worst season(s): ❑winter ❑spring ❑summer ❑fall ❑n/a

Symptoms

If possible, please rank your first and second most bothersome symptoms:

1._____

2._____

Please circle the symptoms that led to this appointment even if they are not present now:

EYES
Dark circles
Burning
Itching
Watering
Redness
Swelling
Pain
Blurred Vision

NOSE
Congestion
Drainage
Itchy
Sneezing
Postnasal drip
Green/yellow mucus
Nosebleeds
Sniffling
Decreased sense of smell
Decreased sense of taste
Snorting
Nasal speech
Snoring
Nasal or sinus polyps
Fracture

THROAT
Sore
Postnasal drip
Tickle
Throat clearing
Itching

CHEST
Cough
Wheeze
Short of breath at rest
Short of breath exertional

HEADACHE
Location: _____
Quality
____Pressure
____Ache
____Throbbing
____Constant
____One-sided
____Both sides

OTHER SYMPTOMS (circle or list to right)
Fever
Night Sweats
Weight Loss unintentionally
Poor appetite

_____
_____
_____
_____
_____

2. MEDICATIONS Please include both prescription and over-the-counter drugs.

A. Current allergy and asthma medications

	Name of Drug	How Much?	How Often?	As Needed or Regularly?	How helpful is it?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

B. Previously tried allergy and asthma medications

	Name of Drug	How Much?	How Often?	As Needed or Regularly?	Reason Stopped
1					
2					
3					
4					
5					
6					

C. Current medications for non-allergy problems, or ❑ list attached

	Name of Drug	How Much?	How Often?	As Needed or Regularly?	For What Problem?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

3. ENVIRONMENT

Primary residence
Age of dwelling _____ years
Time at this residence _____ years
Location ❑city ❑rural
A/C ❑yes ❑no
Basement ❑dry ❑damp ❑none
Pillow ❑feather ❑non-feather ❑both ❑none
Mattress or futon ❑yes ❑no
Bedroom carpet _____ years old ❑none
Furry pets indoors ❑none ❑cat(s) ❑dog(s)
❑other pets: _____
Smoke exposure indoors ❑yes ❑no

Secondary residence if applicable(____% of time here)
Age of dwelling _____ years
Time at this residence _____ years
Location ❑city ❑rural
A/C ❑yes ❑no
Basement ❑dry ❑damp ❑none
Pillow ❑feather ❑non-feather ❑both ❑none
Mattress or futon ❑yes ❑no
Bedroom carpet _____ years old ❑none
Furry pets indoors ❑none ❑cat(s) ❑dog(s)
❑other pets: _____
Smoke exposure indoors ❑yes ❑no

Patient smoking history

Has the patient ever smoked more than experimentally? ❑Yes ❑No
Current smoker? ❑Yes ❑No
If a current or past smoker, how many years smoking/smoked? _____
How many packs(average) a day when smoking? ____ packs per day
If patient has stopped smoking, how many years ago? _____ years ago

Hobbies

1. _____
2. _____
3. _____
4. _____

4. PAST MEDICAL HISTORY

A. Please list all surgeries and the dates they were performed:

	Name of surgical procedure	Date performed
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

B. Please list all hospitalizations for non-surgical reasons:

	Reason for hospitalization	Date hospitalized
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

5. FAMILY MEDICAL HISTORY

Has the patient's mother, father, sister(s) or brother(s) been affected by any of the following ailments?

	Relationship to patient
Asthma	_____
Hay fever	_____
Hives	_____
Eczema	_____
Immune defect/deficiency	_____
Cystic fibrosis	_____

6. DRUG ALLERGY

	Name of Drug	Approximate Date of Reaction	Symptoms Caused by Drug
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

7. FOOD ALLERGY

	Suspected Food	Symptoms Caused by the Food	Amount of Time that passed between eating and the start of symptoms
1			
2			
3			
4			
5			
6			
7			
8			

Is there anything in particular you wanted to get out of coming to see Dr. Frick? Any particular question or questions you wanted to ask? Or any particular test you desired? _____

_____

Thank you for taking the time to complete this questionnaire!

IMPORTANT!!!!

Please be aware that some medications may prevent us from performing valid skin tests.
If you are taking one of these medications, please ask the health care professional who prescribed it whether or not it is appropriate to stop such medication before coming to our office.

DRUGS THAT BLOCK ALLERGY SKIN TESTS

(the typical time required off the drug before valid tests can be performed is in parentheses)

Antihistamines – (5 days)
Examples include Allegra, fexofenadine, Clarinex, Claritin, any form of loratidine or cetirizine, Zyrtec, Xyzal, Atarax, hydroxyzine, doxylamine succinate, and cold medicines that contain antihistamines.
An exception is **azelastine nasal spray (2 days).

Tricyclic antidepressants

1. amitriptyline(Elavil, Endep, Emitrip, Enovil) - (7 days)
2. amoxapine(Asendin) - (7 days)
3. desipramine(Norpramin, Pertofrane) - (2 days)
4. doxepin(Adapin, Sinequan) - (6 days)
5. imipramine(Tofranil) - (10 or more days)
6. nortryptyline(Pamelor)- (7 days)
7. protryptline(Vivactil) - (7 days)
8. trimipramine(Surmontil) - (7 days)
9. clomipramine(Anafranil) - (7 days)

Tetracyclic antidepressants (10 days, occasionally longer)

1. maprotiline(Ludiomil)
2. mirtazapine(Remeron)

Phenothiazines (7 days)

1. chlorpromazine(Thorazine, Largactil)
2. fluphenazine(Thorazine, Prolixin)
3. perphenazine(Trilafon)
4. prochlorperazine(Compazine)
5. thioridazine(Mellaril)
6. trifluoperazine(Stelazine)

Benzodiazepines (7 days)

1. clonazepam
2. diazepam
3. lorazepam
4. midazolam

Other (3-7days)

1. risperidone(Risperdal) (7days)
2. clonidine (7days)
3. meclizine (4 days)
4. bupropion (3 days)
5. eszopiclone (3 days)
6. quetiapine (7 days)
7. trazodone (3 days)
8. zolpidem (3 days)

No effect - nifedipine, montelukast (Singulair), cimetidine, ranitidine, Mucinex, all SSRI's (eg Paroxetine, escitalopram, Lexapro, Prozac, fluoxetine).