ASTHMA & ALLERGY ASSOCIATES, PC AND RESEARCH CENTER

Patient Registration Form: (Please Print)

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Drivers Lic#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____ Alternative Phone Number: (____) _____

Email Address: _____

Primary Care Physician: _____ Referring Physician: _____

Which Pharmacy do you use? _____ Location: _____ Prescription Insurance: _____

Prescription Insurance ID: _____ Mail Order Pharmacy Info: _____

How did you hear about us? _____

Please list other family members treated in our office: _____

Parent/Legal Guardian ****If under the age of 18****

Mother's Name: _____ Mother's DOB: _____

Mother's Employer _____ Employer Address _____

Father's Name: _____ Father's DOB: _____

Father's Employer _____ Employer Address _____

****Please note: All children under age 18 must be accompanied by their legal parent or legal guardian for all office visits and procedures. Exceptions will be made for children who have proof of court ordered guardianship or notarized authorization from the parent allowing another individual to accompany the child for office visits. Parents and guardians will be asked to show identification and any applicable supporting documents.**

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder DOB: _____

Policy Holder SSN: _____ Policy Holder SSN: _____

Relation to Patient: _____ Relation to Patient: _____

EMERGENCY CONTACT: Name _____ Phone Number _____

I certify with my signature below that the information that I have provided is accurate and current. I consent to medical treatment for myself or minor child as the patient/legal guardian.

Signature: _____ **Date:** _____

ASTHMA & ALLERGY ASSOCIATES, PC
AND RESEARCH CENTER

Financial policy of Asthma & Allergy Associates, P.C. (The Practice)

The following is the financial policy of the practice which is required of all patients and/or guardians of patients to read and sign prior to treatment. Your portion of the payment is due at time of service. We expect payment in full for any copays, deductibles, co insurance and/or cost share deemed your responsibility by your insurance.

1. **Credit Card on File**. All patients of the practice are required to place a valid credit card on file. We accept Visa, Mastercard, Discover, Amex. We do not accept Care Credit or gift cards. You will be required to issue to the practice a credit card to place on file to pay for your balance due after insurance has processed. This balance may include Copays, deductible and/or co-insurance, cost share and/or denied or non covered services. Your credit card information will be securely tokenized (digitally altered for security purposes) within the electronic health records system for one year. Please be prepared to pay towards your deductible and/or patient responsibility at time of service and to supply a valid credit card account number for future balances. You will be notified that you have a balance due via text/email prior to the practice charging your credit card. The practice will charge your credit card any balances due after insurance has processed your claims and a statement and receipt will be mailed to you. By signing the financial agreement below, you are authorizing the practice to charge your credit card for balances due.
    a. If you prefer to pay with cash or check, payment in full at time of service will be expected. We will still require a valid credit card on file, however we will accept cash or check if you wish to avoid charges to your card. Please call us before your appointment/antigen order to obtain an estimate at 719-473-1800 option 5. The amount that you will be quoted is an estimate and may not be the correct amount owed in which case your credit card on file will be charged for the balance or a refund check will be issued for overpayment.
2. **Payment Plans**. Payment plans are not offered by the practice.
3. **Delinquent accounts** over 90 days past date of service will be written off by the practice as bad debt and sent to a third party collection agency. If your account is sent to a collection agency, the practice will terminate the Physician/patient relationship and you/the patient and patient's immediate family will not be able to receive future services from the practice.
4. **Returned checks** will be charged a $35 insufficient funds charge in addition to the original amount due.
5. **Patient Refunds** will only be issued in the case of incorrect billing or receipt of over payment. In the event of a refund, your refund will be issued to the original credit card that was charged within 30 days of your final insurance processing.

The practice will file insurance claims with most standard carriers including Indemnity, HMO, PPO and Government issued insurance. It is the patient's responsibility to ensure that the practice has accurate insurance information including prior authorizations if needed. If, for any reason, your insurance claims are denied or unpaid, the patient becomes solely responsible for payment of the services. By this agreement, the patient authorizes the exchange of information relating to care and claims to and from the patient's health insurance carrier as well as the practice's third party billing staff. The patient authorizes payment from their insurance company to be made directly to the practice.

I certify with my signature below, that I authorize medical treatment of the person named below and I agree to the financial agreement as outlined above. I authorize payment of my insurance benefits to be made directly to Asthma & Allergy Associates for any service rendered by a physician or practitioner employed by the practice. I authorize the release of medical information needed to complete insurance claims, to communicate with my primary and/or referring doctor's office, and to coordinate care with outside physicians, laboratories, pharmacies or facilities. I authorize the practice to charge my credit card on file for balances owed by me as the responsible party.

Patient Agreement: I have read and understand the Financial Policy above and agree to the terms. I understand that this agreement does not have an expiration date and will remain in effect the duration of my care with the practice. Altered versions of this agreement are not valid.

_____ _____

Signature (Patient/Guardian if under 18) Printed Name (Patient/Guardian if under 18)

Date: _____ Social Security Number _____-_____-_____

INSURANCE VERIFICATION

In order to help you determine out of pocket costs with your insurance, below are typical CPT codes that we use to bill insurance. We highly encourage you to call your insurance company to find out if the visit or procedure we will be administering is paid for by your insurance or whether it will be subject to your copay, deductible, co-insurance or out of pocket maximum. We do collect at time of service towards your expected patient liability. The CPT codes provided are meant to be used as a guide and may or may not be all inclusive of all charges and or procedures used for your visit. Please note that it is the patient's responsibility to obtain prior authorizations and referrals if required and to verify benefit coverage. If you would like our assistance in determining your level of coverage, please call 719-473-1800 Option 5 prior to your appointment.

New Patient with Environmental and Food Allergy Testing

- 99204 Office Visit
- 95004 Percutaneous tests
- 95024 Intracutaneous tests
- 94375 Spirometry
- 94060 Bronchospasm Evaluation

***The average cost for a new patient with testing is between $600-$900. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

Established Patient with Allergy Retesting

- 99214 Office Visit
- 95004 Percutaneous tests
- 95024 Intracutaneous tests
- 94375 Spirometry
- 94060 Bronchospasm Evaluation

****The average cost for an existing patient with testing is between $500-$800. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

Antigen and Injections

- 95165 Antigen Serum (per unit)
- 95115 1 injection
- 95117 2 or more Injections

*****The average cost for a year's supply of antigen and injections is between $1,500-$2,500. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

OIT, Peanut and other Food Challenges

- 95180 Rapid desensitization per hour
- 95076 Ingestion challenge initial 120 minutes
- 94375 Spirometry
- 99214 or 99213 Office Visit

****The average cost of OIT is between $250-$450 per visit and is determined by the length of time your visit requires. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

Xolair and Nucala Administration (Biologic Administration)

- 99213 or 99214 Office visits
- 96401 Xolair Administration
- 94375 Spirometry

****The Average cost of biologic administration is between $185-$300 per visit. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

Metals testing (Patch test)

- 99213 or 99214 Office visits
- 95044 Patch test application (per test/application)

****The average cost of metals testing is between $500-$700 and depends on the quantity of tests applied. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

Venom Testing

- 99204 or 99214 Office visits
- 95017 Venom testing
- 95076 Ingestion challenge
- 95004 Percutaneous tests
- 95024 Intracutaneous test
- 94375 Spirometry

****The average cost of venom testing is between $900-$1,500. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

Antibiotic Testing

- 99214 or 99213 or 99204 Office visits
- 95018 drug allergy testing
- 95004 percutaneous testing
- 95024 intracutaneous testing
- 94375 Spirometry

****The average cost of drug/antibiotic testing is between $900-$1,500. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

Routine Follow up Visits

- 99214 or 99213 Office visit
- 94375 Spirometry

****The average cost of a follow up visit is between $95-$200. Your insurance may pay all of it, part of it, or none of it. Please verify with your insurance before your visit to determine your level of coverage.

I certify by my signature below that I understand the costs associated with the service(s) that I have requested. I have verified my level of insurance coverage and understand that I may be financially responsible for the service(s) requested for myself or my minor.

Printed Name:_____ Date:_____

Signature:_____

ASTHMA & ALLERGY ASSOCIATES, PC

Electronic Communication (E-mail) Agreement

Electronic (online) communications include e-mail, webmail, secure messaging, electronic file transfer, text messaging and internet "portals" to exchange information between computers, tablets, smartphones. These can be useful ways for patients and healthcare providers to communicate, in addition to more usual visits and phone calls.

Advantages

- E-mail is a simple, convenient and popular way of connecting; many people use it regularly
- Messages can be sent and received without needing both parties online at the same time
- Messages can be saved, copied and forwarded; they keep a record of what was said
- Some messaging systems are encrypted to help keep information private
- Some questions and issues can be handled by online messaging without a phone call or visit

Disadvantages

- E-mail devices and connections can fail, messages can be lost or sent to the wrong person
- There is no way to know if a message was ever received
- Messages can contain typing mistakes
- If the other party is away or their device is turned off, messages might not be seen promptly
- It is possible for a dishonest person to send a false message or impersonate a patient or a doctor
- If both parties are not online at the same time, there is no opportunity to clarify misunderstandings
- Saved copies or messages sent in error can't be erased or retracted
- Messages can contain viruses that can damage systems or steal information
- Some medical questions and issues cannot be handled through online messaging

Our E-mail Policies

1. **No emergencies or urgent messages.** E-mail is not to be used for emergencies or urgent messages. We do not monitor our In-Box constantly. You can send a message any time, but we may not read it until the next business day. We check messages during regular work hours, and answer them in the order received. We try to deal with messages within 1 work day, but circumstances could cause us to fall behind. Use the telephone if you need a response right away. Of course, in a life-threatening emergency call 911.

    a. **Uses.** Our practice accepts E-mail messages through our web site, www.aacos.com or through our Patient Portal. If you would like to set up your Patient Portal call our main office at (719)473-0872 or (800)533-3900 for log in information.

    b. **General messages** like making or changing appointments, billing issues, or other questions that can be answered by any appropriate staff person.

    c. **Medical questions.**

    d. **Prescription renewals.** You can request refills of medicines we have previously prescribed, the same way as leaving a phone message. If we have a question for you, we may respond by E-mail or phone. Use our patient Portal

2. **Part of the record.** E-mail messages are considered part of your medical record. Our policies for record privacy and appropriate uses of medical information apply to messages we send to each other.

3. **Security.** You need to protect the E-mail address you give us, to make sure our communications remain private. This is the only way we can trust that messages from your E-mail are really from you, and messages we send are not going to someone else. If we aren't sure about a message, we will try to contact you in some other way.

4. **Availability.** If you ask us to use E-mail to communicate with you, we will assume that you check your In-Box at reasonable intervals. We don't guarantee that we will respond to your messages and we understand you can't guarantee that you will respond to ours. In cases of uncertainty, we will try other ways of communicating.

5. **Sensitive medical information.** We can't always know what information you consider especially private. We take care with all medical records, but we know that some facts are more sensitive than others. Because E-mail can't be guaranteed 100% secure, please don't put extremely sensitive matters in messages without considering this.

6. **Voluntary.** Using E-mail is voluntary for both of us. If we feel you are using E-mail inappropriately (or, if we think your address has been hacked by an imposter), we may block your messages. If you decide you don't want to receive E-mail from us any longer, just let us know.

7. **Changes of address.** If your E-mail address changes, you need to let us know.

8. **Non-essential uses.** We will only use your E-mail address for important communications related to our practice. We will not give your E-mail address to anyone who is not part of our practice. Please don't send non-essential messages to us, because they slow down our ability to respond to the important ones.

9. **Mistakes.** Mistakes happen. If you believe you have received or sent a message by mistake, or one that contains errors, please let us know. You should delete messages that are not intended for you.

10. **Other risks.** In addition to those above, electronic communication can have other risks and disadvantages that might cause inconvenience or harm. Everyone using E-mail needs to use good judgment about these valuable technologies, and must remember that there are alternatives that would be better for some situations.

Acknowledgement and Agreement

I acknowledge that I have read this form. I understand that electronic (online) communication has risks, including possible risks not mentioned above. I agree to abide by the policies described above. I agree to use reasonable judgment with regard to any messages I send or receive. I do not have any unanswered questions about what this Agreement requires.

Patient (or legal representative) name: _____

Signature: _____ **Date:** _____

E-mail address to be used: _____

ASTHMA & ALLERGY ASSOCIATES, PC
AND RESEARCH CENTER

MEDICAL HISTORY

Date: _____

Name: _____ DOB: ___/___/_____ Age: _____ M ☐ F ☐

Who is your PCP: _____ Referred by: _____ Reason Referred: _____

Local Pharmacy & Location: _____ Mail Order Pharmacy: _____

How long has patient lived in Colorado? _____ Where did patient live previously? _____

What brings you in today? _____

_____

_____

_____

List pets in the home and outside: _____

Current Occupation: _____

Favorite activities/hobbies/sports: _____

_____

Immunizations (month/year) **Child Vaccines Current:** ☐ **Yes** ☐ **No**

COVID19: _____ Influenza: _____ Pneumonia: _____ Shingles: _____ Tdap: _____

COVID19 Testing (mm/dd/year, result): _____

Chronic Illnesses	Date of Onset	**Surgeries/Hospitalizations**	Date

Current Medications: List all prescriptions and over the counter medications taken routinely or as needed.

Medication Allergies/Intolerances	Reaction	Date

Food Allergies/Intolerances	Reaction	Date

FOR INFANT/TODDLER PATIENTS ONLY

Birth History: ☐ Vaginal ☐ C-section

Birth Complications: _____

_____

Diet History: Breastfed ☐ Yes ☐ No

How Long? _____

Formula(s) ☐ Yes ☐ No

What Type(s)? _____

_____

Is patient exposed to tobacco: ☐ Yes ☐ No **Is patient exposed to marijuana smoke:** ☐ Yes ☐ No

Do you currently smoke tobacco? ☐ Yes ☐ No

Do you currently chew tobacco? ☐ Yes ☐ No

How many years did you smoke? _____

When did you quit Smoking? _____

Formerly smoked tobacco? ☐ Yes ☐ No

Formerly chewed tobacco? ☐ Yes ☐ No

Average number cigarettes per day: _____

Are you interested in quitting? ☐ Yes ☐ No

Marijuana use? ☐ Yes ☐ No Type: _____

Medical use? ☐ Yes ☐ No Medical reason: _____

Do you Vape? ☐ Yes ☐ No

How many years did you Vape? _____

Do you drink alcohol? ☐ Yes ☐ No Drinks per week: _____ How many caffeinated drinks per day? _____

	Hayfever	Asthma	COPD	Hives	Eczema	Chronic Sinus Problems	Nasal Polyps	Bee Allergy	Adverse Drug Reaction	Food Allergy	Chronic Bronchitis	Thyroid Disease	Anemia	Blood Clots	Cancer	
Mother																
Father																
Daughter(s)																
Son(s)																
Sister(s)																
Brother(s)																

Previous Allergy Testing/Evaluation(s): ☐ **Yes** ☐ **No** **Date(s):** _____

Allergist Name: _____ **City:** _____ **State:** _____

Skin testing: ☐ Yes ☐ No Blood testing for allergy: ☐ Yes ☐ No Were you allergic? ☐ Yes ☐ No

If allergic, was it to: ☐ trees ☐ grass ☐ weeds ☐ animals ☐ dust mites ☐ mold ☐ food(s)

Previous allergy injection(s): ☐ Yes ☐ No Date(s) of treatment: _____

How long did you take shots? ☐ 6 months ☐ 1 year ☐ 2 years ☐ 3 years ☐ Longer _____

Were allergy injections beneficial? ☐ Yes ☐ No ☐ Not Sure

Adverse reactions to allergy injection(s)? ☐ Yes ☐ No

ASTHMA & ALLERGY ASSOCIATES, PC
AND RESEARCH CENTER

Review of Symptoms

[Mark symptoms you have experienced in last 4 weeks]

Constitutional	
	Weight Loss/Gain
	Fatigue
	Fever
	Headache
	Recent Illness

Eyes	
	Blurred/Double Vision
	Glaucoma
	Cataracts
	Puffiness Around Eye(s)
	Eye(s) Discharge
	Itchy Eye(s)
	Eye(s) Tearing

Ears, Nose, Throat	
	Sneezing
	Earache
	Hearing Loss
	Ringing in Ears
	Dizziness
	Ear Discharge
	Nosebleeds
	Nasal Congestion
	Plugged Ears
	Itchy Nose
	Sinus Trouble
	Sinus Infection(s)
	Hoarseness
	Runny Nose
	Sore Throat
	Postnasal Drip
	Thyroid Trouble

Respiratory	
	Chest Tightness
	Cough
	Shortness of Breath
	Wheezing
	Phlegm

Cardiovascular	
	Chest Pain/Pressure
	Heart Trouble
	Murmurs

Dermatological	
	Rashes
	Lumps
	Itching
	Eczema
	Hives
	Changes in Skin, Hair, or Nails

Gastrointestinal	
	Trouble Swallowing
	Stomach Problems
	Vomiting
	Heartburn
	Loss Appetite
	Constipation
	Diarrhea
	Hemorrhoids
	Liver Disease
	Gallbladder Disease

Genitourinary	
	Urine/Burning
	Blood in Urine
	Urinary Frequency
	Urinary Incontinence
	Infections
	Kidney Stones

Musculoskeletal	
	Joint Pain
	Joint Swelling
	Rheumatoid Arthritis

Mental Health	
	Anxiety
	Depression
	Panic Attacks
	ADD/ADHA

Hematology	
	Varicose Veins
	Blood Clots
	Abnormal Bleeding
	Abnormal Bruising
	Anemia

Allergy/Immunology	
	Hypogammaglobulinemia
	Anaphylaxis Reaction
	Angioedema
	Food(s) Allergy
	Hives

Office use:

ASTHMA & ALLERGY ASSOCIATES, PC
AND RESEARCH CENTER

Notice of Health Information Privacy Practices: This notice describes how medical information about you or your child may be used and disclosed and how you can get access to this information. Please read and review this notification carefully.

Asthma & Allergy Associates, PC (the practice) is required to maintain the privacy of your health information, and to provide you with a copy of this notice. This notice applies to all of the medical records generated by the practice as well as records the practice receives from outside providers.

Use & Disclosure of Protected Health Information in Treatment, Payment & Health Care Operations.

Treatment: The practice may use and disclose your protected health information in the course of managing your health care as well as any related services. Unless you advise us in writing not to, we may coordinate your care with a third party, including pharmacies, billing services, laboratories, or another physician. We may disclose your protected health information to other health care providers/professionals related to your care including, but not limited to your primary care physician or referring physician.

Payment: The practice will use or disclose your protected health information to obtain payment for services rendered. This may include verifying your insurance, determining benefits eligibility, faxing or emailing records to your insurance company. The practice uses a third-party billing service and your protected health information is accessible to billing staff outside of the practice.

Operations: The practice may use or disclose your protected health information for the purposes of management or administration of the practice. This may include but not limited to the following. 1) Quality evaluations/improvement activities 2) Employee training 3) Accreditation, certification, licensing, and credentialing 4) Compliance reviews and audits including legal activities

Other Uses: The practice may use or disclose your information 1) to remind you of an appointment or financial obligation for services 2) to inform you of potential treatment plans or alternatives or of services that might be of benefit to you including research 3) detailed messages with regard to your health care, medications, insurance benefits or financial responsibilities may be left by the practice on your voice mail, email and/or text. 4. The practice may disclose your protected health information to a friend or family member or caretaker who is involved in your care as you have designated on the accompanying from titled "Authorization to Disclose Protected Personal Health Information".

Research: The practice may use or disclose your protected health information for approved clinical studies. You may be contacted by a member of the practice's research staff for current or upcoming research study participation.

Regulatory Agencies: The practice may disclose your health information to government and health oversight agencies for activities authorized by law, including but not limited to audits, investigations, inspections and licensure. The practice may disclose your information to public health or legal authorities, physicians or other professional entities who are charged with preventing or controlling disease, monitoring or deciding disability, monitoring or deciding worker's compensation and those charged with monitoring injuries or abuse. If applicable, the practice will disclose your information to organ and tissue procurement organizations for the purpose of donation or transplant.

Law Enforcement/Litigation: The practice may disclose your protected health information to law enforcement, lawyers, or use your information in a court of law or other processes in litigation. If applicable, the practice may disclose your information to military command authorities.

Uses and Disclosures Requiring your Authorization: Other than the above circumstances, the practice will not disclose your or your child's protected health information unless you provide written authorization. You may revoke your authorization in writing at any time.

Your Rights Related to your Health Information:

1. You have the right to confidential communications of your protected health information.
2. You have the right to inspect and copy your protected health information.
3. You have the right to request an amendment of your health information.
4. You have the right to obtain a statement of the disclosures that have been made of your protected health information.
5. You have the right to request restrictions on certain uses or disclosures of your protected health information.
6. You have the right to a copy of this notification.
7. You have the right to revoke your authorization to use or disclose your health information.
8. You have the right to be notified in the event of a breach of protected health information.
9. You have the right to file a complaint without the risk of retaliation to the US Secretary of Health and Human Services.

For more information regarding how to exercise these rights, please contact the Practice Clinic Administrator at (719)473-0872. **This notification is effective for all protected health information created on or after October 1, 2019.**

ASTHMA & ALLERGY ASSOCIATES, PC
AND RESEARCH CENTER

PATIENT NAME _____ DOB _____

Authorization to Disclose Protected Personal Health Information

Asthma & Allergy Associates, PC (the practice) may use or disclose your protected health information only with your consent. Your signature below authorizes the practice to disclose information about you or your child/minor in your care as set forth in the document titled "Notice of Health Information Privacy Practices" issued to you by the practice. Your signature below authorizes the practice to electronically download your medical history including medication history as it is available from pharmacies and other medical facilities. The practice may disclose information about you without your consent to government authorities for other purposes. Examples of such uses or disclosures include suspected abuse and/or infection diseases.

You have the following rights regarding your protected health information, and the practice must act on your written request within 60 days for the following items.

1. You may request restrictions on certain uses and disclosures. The practice will review your request and decide whether to grant restrictions.
2. You may request that you receive confidential communication of protected information.
3. You may request to inspect and copy your own protected health information.
4. You may request that your information be amended.
5. You may request to revoke this authorization at any time.

The law requires the practice to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices. The law requires the practice to abide by the terms of this notice and to provide individuals with notice revisions. If you feel as though your rights have been violated, you have the right to complain to the US Department of Health and Human Services and to notify the Clinic Administrator of the practice at (719) 473-0872.

By my signature below, I agree to the terms of this authorization and agree to the terms set forth in the accompanying document titled "Notice of Health Information Privacy Practices". By my signature below, I acknowledge that I have received a copy of the practices notice of privacy practices.

I authorize the following people to be allowed access to my or my child's Protected Health Information including medical records, school forms, insurance claims, medications, financial information and research participation if applicable. I authorize the following people to pick up documents as applicable or medications on my behalf or my child's behalf.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Patient Signature:_____ Patient DOB_____ Today's Date_____

Parent Guardian Signature if Patient is under age 18_____ Date _____

This Authorization does not have an expiration date as it remains in effect until revoked.

Medication Guideline for Skin Testing

The following is a list of medications that you will need to discontinue prior to your appointment for accurate test results. If you have any questions on the contents of your medications, please call your pharmacist. If you feel that you are **not** able to discontinue using any of these mediations for any reason, please contact our office for guidance at 719-473-0872. Please **DO NOT** discontinue medications prescribed for chronic medical conditions such as asthma, heart, or psychological disorders without first discussing with the prescribing physician.

Antihistamines: Discontinue 5 days prior to appointment

Antihistamine Name:	**Also Known As:**
Cetirizine	**ZYRTEC**, Wal-Zyr, Aller-Tec
Loratadine	**CLARITIN**, Wal-Itin, AllerClear, Alavert
Fexofenadine	**ALLEGRA**, Wal-Fex, Aller-Fex
Diphenhydramine	**BENADRYL**, Wal-Dryl, UNISOM, Zzz-Quil
Levocetirizine	**Xyzal**
Desloratadine	Clarinex
Chlorpheniramine	Chlor-Trimeton, Chlor-Tabs, Aller-Chlor
Hydroxyzine	Atarax, Vistaril
Doxepin	Sinequan, Adapin
Cyproheptadine	Periactin
Clemastine	Dayhist, Tavist

Nasal Sprays: Discontinue 7 days prior to appointment

Nasal Spray:	**Also Known As:**
Azelastine	**Astelin, Dymista**
Olopatadine	Patanase

Eye Drops: Discontinue 5 days prior to appointment

Eye Drop:	**Also Known As:**	**Eye Drop:**	**Also Known As:**
Olopatadine	**Pazeo, Patady, Patanol**	Alcaftadine	Lastacaft
Ketotifen	Zaditor, Alaway	Bepotastine	Bepreve
Azelastine	Optivar	Pheniramine	Naphcon A, Opcon A
Epinastine	Elestat		

Most cold medications also contain antihistamines.

- Check the back of your medication box or bottle for: **chlorpheniramine, doxylamine, or diphenhydramine, brompheniramine**
- Be aware of anything that says **COLD & FLU**
- Be aware of anything that says **NIGHTTIME or PM**

By signing this form below, I acknowledge that I have read and reviewed the above Medication Guideline and have discontinued such meds accordingly. I understand that if I have not stopped medications listed, I may no longer be a candidate for allergy testing at this time. Therefore, I may need to reschedule my testing for the next available appointment.

Signature: _____ Date: _____