BLUEGRASS FAMILY ALLERGY

PERSONALIZED ASTHMA & ALLERGY CARE

KELLY S. BRAUER, MD, FACAAI, FAAAAI

Welcome to our practice!

We look forward to meeting you at the time of your first appointment. Please call us at least 24 hours in advance if you must cancel, so we can fill the time slot with other patients who may be waiting to be seen. Arrive 15-30 minutes early to fill out new patient paperwork, or you may print it from our website at www.bluegrassfamilyallergy.com and fill it out at home in advance of your appointment. Should you arrive more than 15 minutes late, your appointment may need to be rescheduled in an effort to see all our patients in a timely manner. We realize your time is valuable and we want to give you prompt care if at all possible. If you do not call 24 hours in advance to cancel an appointment, a $25 "no-show" fee will be assessed for regular appointments and a $50 fee for a missed testing appointment.

Due to the large amount of information asked during your initial visit, we ask that any patient under the age of 18 be accompanied by their parent or legal guardian (please bring paperwork indicating guardianship). If a parent is unable to accompany the patient, we ask that a copy of the parent's driver's license and insurance card are included with the Registration Form. We also ask that you ensure whoever is bringing the patient to the appointment is listed on the Registration Form.

Skin Testing & Procedure Information

If it has been determined that you will need skin testing, Dr. Brauer will have you return after having held your antihistamines for an appropriate amount of time, as these block our skin testing results. Our staff will review what specific medications will need to be stopped in order to conduct the testing. Many insurance plans will not provide coverage for testing at the initial consultation visit. When you return for testing, you should expect your visit to last at least 45 minutes.

After Hours Coverage

Our phone hours are 8:00 AM-4:00 PM Monday, Tuesday, Wednes and Friday, but note that our office is closed on Thursdays. Please see our website at www.bluegrassfamilyallergy.com for any updates or questions about these hours. During regular clinic hours, someone will be available to answer your questions as promptly as possible by calling our office at **270-228-2811.** We return all calls promptly, and at least by the end of business each day.

Prescription Refills & Drug Samples

Please call your pharmacy if you need a prescription refilled, and have them fax a refill authorization to **270-228-2812**. Allow us 24 hours to process your refill. Note: Patients on regular maintenance medications are required to be seen in at least 6-12 month intervals. If it has been more than 12 months since your last appointment, we will request that you be seen before further refills.

Financial policies

Co-pays are due at time of service, no exceptions. If your policy has a deductible that has not been met or co-insurance (percentage) that will need to be paid, we may ask for this amount in advance of your visit. Our office makes every attempt to estimate your owed amount on each claim and inform you of your total financial responsibility in advance of your appointment, but this is not always possible.

Please be sure to verify our participation with your insurance provider prior to your appointment. If Dr. Brauer does not participate with your insurance plan or the services rendered are not covered by your plan, payment will be expected at the time of service.

If your insurance company denies payment to Bluegrass Family Allergy, PLLC for services performed, you accept full responsibility for the charges incurred. If your insurance requires a referral, you are responsible for obtaining this and bringing it to your appointment.

If you are unable to pay for services when they are rendered, please telephone our insurance and billing coordinator before your visit to establish a payment plan. If plans are not made prior to your visit, we may request that you reschedule. Any outstanding balance that is more than 30 days past due will have a 2.5% per month finance charge added to the balance. If your account is more than 90 days past due, and you have not made arrangements with our billing department, your account will be considered suspended. Until payment arrangements are made you will not be allowed to incur further charges for routine care, but will be provided care on an emergent basis only. Any accounts over 90 days past due without other arrangements will be considered for transition to an outside collections agency. A $25 fee will be charged for any returned checks. Please call our billing office toll-free at **(855) 780-8132** for questions about your account.

You agree, in order for us to service your account, to allow us to notify you of information pertaining to your account or medical condition or for the purposes of collection, we may contact you by telephone at any number provided by you, including wireless numbers. We may also contact you by email or text message if you provide us this information.

Dr. Brauer's credentials

Dr. Kelly S. Hagan Brauer was born and raised in Philpot, Kentucky and graduated valedictorian of Owensboro Catholic High School in 1995. She attended the University of Kentucky where she received a bachelor's degree in Biology and was a member of Chi Omega sorority. She stayed in Lexington for another 4 years and graduated with honors from University of Kentucky Medical School in 2003. She then moved to Tampa/St. Petersburg, Florida to complete a residency in Pediatrics at the University of South Florida in 2006. She began her Allergy/Immunology Fellowship at the Cincinnati Children's Hospital/University of Cincinnati Program, and completed her specialty training in 2008 at the Medical College of Georgia in Augusta.

Dr. Brauer has been practicing in the Owensboro area since 2008 and opened her own practice, Bluegrass Family Allergy PLLC in 2015. She maintains her board certification in Allergy/Immunology, and enjoys seeing patients of all ages for asthma, food allergies, skin conditions, and other allergic conditions of the respiratory system. She is a fellow of the American College of Allergy, Asthma, and Immunology as well as of the American Academy of Allergy, Asthma, and Immunology, and serves as President of the Southeastern Allergy, Asthma, and Immunology Society. She specifically enjoys treating food allergies and providing community education, and considers it her duty as an allergist to educate the public on the dangers and pitfalls of food allergies. If you have a group or organization that you feel may be beneficial for her to talk with, please discuss this with our office staff and we would be happy to oblige.

Dr. Brauer and her husband, Tom, a Maryland native, enjoy being here in Owensboro close to family. They spend most of their time outdoors and attending the activities of their 5 children.

We hope you find our office pleasant and comfortable, as well as our staff friendly and helpful. Our goal is to provide quality, personalized, state-of-the-art services in a cost-effective manner. Please to not hesitate to call if you have additional questions or comments.

Sincerely,

Dr. Brauer and staff

I understand and agree to all of the policies described on this document. I have received a copy for my records.

_____ _____

Signature/Date Printed Name and Relationship (if not the patient)

_____

Witness/Date

PATIENT REGISTRATION FORM

PATIENT NAME _____

(LAST) (FIRST) (MI) (SOC SECURITY #)

STREET/PO BOX_____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

BIRTH DATE _____ ☐MARRIED ☐DIVORCED ☐SINGLE ☐WIDOWED ☐MALE ☐FEMALE

PATIENT EMPLOYER_____OCCUPATION _____

EMERGENCY CONTACT & PHONE #_____

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☐SPOUSE INFORMATION OR ☐PARENT INFORMATION (If parent information, please complete both sections completely)

NAME_____

ADDRESS _____

CITY _____STATE_____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____

SS# _____ BIRTHDATE_____

EMPLOYER _____

NAME _____

ADDRESS _____

CITY _____STATE_____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____

SS# _____BIRTH DATE _____

EMPLOYER _____

****

PRIMARY INSURANCE

INS NAME _____

ADDRESS _____

CITY_____ ST _____ ZIP _____

PHONE _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____

POLICY HOLDER BIRTHDATE _____

POLICY ID/GRP#_____

SECONDARY INSURANCE

INS NAME _____

ADDDRESS _____

CITY _____ ST _____ ZIP _____

PHONE _____ EFFFECTIVE DATE _____

POLICY HOLDER NAME _____

POLICY HOLDER BIRTHDATE _____

POLICY ID/GRP #_____

PRIMARY CARE PHYSICIAN AND ADDRESS _____

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ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT: I hereby authorize my signature on all insurance and Medicare claim forms at the office of Bluegrass Family Allergy, PLLC for payment directly to him/her for service rendered to me/patient. I authorize this office to send copies of medical records that may be needed to file insurance claims. I understand that I am responsible for charges incurred regardless of whether my insurance pays or not. I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, a collection fee of 33 1/3% will be added to my account. I agree to pay that fee and any attorney fees and court costs. I understand and agree to the above terms for all current and future claims.

SIGNATURE _____ DATE _____ Rev. 11.16

Initial Allergy Evaluation

Please describe in <u>a few words</u> the main medical problem which prompted you to seek evaluation today.

_____

SYMPTOMS: Are you bothered by the following symptoms?

Itchy/watery eyes	Facial pain/tenderness	Chest tightness
Dark circles under eyes	Nighttime cough	Itchy skin
Runny nose	Loss sense taste/smell	Dry skin
Stuffy nose/congestion	Chronic bad breath	Hives
Nasal itch/rub	History of nasal polyps	Swelling
Bouts of sneezing	Nosebleeds	Frequent ear infections
Ringing/popping ears	Cough	Frequent Pneumonia
Headaches	Wheeze	
Frequent sinus infections	Shortness of Breath	

AGGRAVATING FACTORS: Circle all the things that cause your symptoms.

Dust	Mold/mildew	Time of day – am/pm
Pollen	Colds/infections	Home
Cut grass/rake leaves	Indoors	Workplace
Cats	Outdoors	Temperature changes
Dogs	Weather changes	Food_____
Other animals_____	Smoke	
Feathers	Strong odors	

How long have you had symptoms? _____
Are symptoms worse in certain seasons? Yes No
Circle the worst season(s): Spring Summer Fall Winter

If you have been on antibiotics for sinus infections:
How many times have you been treated in the past 12 months? _____
What antibiotics have you used? _____
Have you ever received a CT scan, chest x-ray or sinus x-ray? Yes No
Have you ever had sinus surgery? Yes No

If you have had cough, shortness of breath, wheezing, or chest tightness:
Have you been on steroids or received a steroid shot for your breathing? Yes No
Have you ever been prescribed an inhaler? Yes No
Do you wake up at night because of chest symptoms? Yes No
Circle any circumstance appropriate to your asthma:
ER visits Hospitalization Intubation ICU admission Pneumonia

If you have had hives or swelling:
How often do you have hives or swelling? _____ When did it first begin?_____
How long does each individual hive last? _____
Have you ever had hives/swelling in the past? Yes No
Do you experience shortness of breath, wheeze, chest tightness, abdominal pain, throat fullness, dizziness, or diarrhea? Yes No (circle where appropriate)
Have you recently experienced fevers, chills, night sweats, swollen glands, swollen joints, weight gain or loss?
Yes No (circle where appropriate)

Current Medicines and Dosages (Prescription and Over-the-Counter):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Medical History/Review of systems

Have you ever been diagnosed with any of the conditions below? Yes No

	Yes	No		Yes	No
ADHD	☐	☐	Migraines/frequent headaches	☐	☐
Asthma	☐	☐	Nasal injury	☐	☐
Cancer	☐	☐	Osteoporosis or Osteopenia	☐	☐
Depression/anxiety	☐	☐	Positive TB skin tests/Tuberculosis	☐	☐
Developmental delay	☐	☐	Prematurity	☐	☐
Diabetes	☐	☐	Prostate disease	☐	☐
Elevated cholesterol	☐	☐	Recurring pneumonias	☐	☐
GERD/Ulcers/GI problems	☐	☐	Seizures/Neurologic disorder	☐	☐
Glaucoma/cataracts	☐	☐	Severe infections	☐	☐
Heart disease	☐	☐	Stroke	☐	☐
Hypertension	☐	☐	Thyroid disease	☐	☐
Irritable bowel syndrome (IBS)	☐	☐	Other _____		
Kidney stones	☐	☐	_____		

Surgical History

Please circle any surgeries you have previously had:

Adenoid removal	Gall bladder removal	Nasal/sinus surgery
Appendectomy	Hysterectomy	Open heart surgery
Ear tubes	Joint replacement	Tonsillectomy

Other: _____

Birth History

Were you born prematurely? Yes No If yes, how many weeks early? _____
Did you have any problems with breathing at birth? Yes No
Any complications/hospital stays in the first year? Yes No
Any developmental delays or special evaluations required? Yes No

Immunization History

Are your routine childhood vaccinations up to date? Yes No if no, why? _____
Do you get a flu shot? Yes No
Have you ever had a reaction to shots? Yes No Please describe _____

Allergy History

Any medication allergies? Yes No Please list and describe reaction: _____
_____
_____
Any problems related to diet? Yes No Please describe: _____
_____
_____
Any insect sting reactions? Yes No _____
Any latex reactions? Yes No _____
Prior allergy testing? Yes No
Were you on injections? Yes No if yes, did they help? Yes No

Family History

Do any of your family members have a history of:

	Who: (father, mother, grandmother, etc.)
Asthma	_____
Cystic Fibrosis	_____
Eczema	_____
Food allergies	_____
HayFever	_____
Hives/Swelling	_____
Insect Sting Reactions	_____
Migraines/headaches	_____
Recurrent infections	_____
Stomach problems	_____
Other	_____
	_____

SOCIAL HISTORY

(please circle)

1. Marital status: Married Divorced Single Widowed
2. Alcohol use: Never/rarely Socially More than 3x/week
3. Exercise: Never/rarely Occasionally More than 3x/week
4. Drug Use: Never In the Past Currently
5. Tobacco Use: Never In the Past Currently

If you answered yes to Tobacco use, please answer the following:

How much? _____

For how many years? _____

If you have quit, when did you stop? _____

Work/School/Daycare

1. What is your occupation? _____
2. If a student, what grade are you in? _____
3. What are your hobbies? _____
4. Are your symptoms worse at work? Yes No
5. Any specific exposures at work? Yes No _____
6. Do you get better on vacation? Yes No
7. How many days did you miss school or work in the past year? _____
8. If child, is he/she in daycare? Yes No
9. How many other persons are in the household? _____

ENVIRONMENTAL HISTORY

General (circle where appropriate)

1. Where do you live? House Apartment Trailer Condo Other: _____
2. How long have you lived there? _____ How old is it? _____
3. Pets (If yes please specify) Yes No

Cat	Indoor	Outdoor	Both
Dog	Indoor	Outdoor	Both
Other:_____	Indoor	Outdoor	Both

4. Smokers in the home? Yes No
5. Is your home air conditioned? Yes No If yes, central or window?
6. Do you keep your windows closed? Yes No
7. Do you have a humidifier? Yes No
8. Do you have an electrostatic air filter? Yes No
9. Do you have moisture problems in your home? Yes No
10. Do you have a basement? Yes No Is it damp? Yes No
11. Do you have: Carpet Wood Vinyl flooring
12. Have you noticed insects or cockroaches in the home? Yes No

ADDITIONAL HISTORY:

Is there any information you think we should know not mentioned elsewhere on this form?

_____

_____

_____

_____