LITTLE ROCK ALLERGY & ASTHMA CLINIC, P.A.

18 Corporate Hill Drive – Little Rock, Arkansas 72205 – (501)224-1156 – FAX (501)223-2625
www.littlerockallergy.com

PRE-REGISTRATION: NEW PATIENT

PATIENT

☐ Dr. ☐ Miss ☐ Ms ☐ Mrs. ☐ Mr. Patient Name_____
(First) (Middle) (Last) nickname if any

☐ Female ☐ Male Date of Birth_____Age_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

☐ Married ☐ Single ☐ Divorced ☐ Widow/er Social Security Number of Patient _____

Address_____Apt._____Lot_____

City_____State_____Zip_____

Home Phone_____ Work Phone_____ Email_____

Patient's Employer/School_____Occupation_____

Name of Spouse_____Date of Birth_____Social Security Number_____

Spouse's Employer_____Occupation_____Work Phone_____

If patient is a minor: Parents: ☐ Married ☐ Single ☐ Divorced ☐ Widow/er

Father's Name_____ Social Security #_____ Date of Birth_____

Address_____City/State/Zip_____ Home Phone_____

Father's Employer_____Occupation_____ Work Phone_____

Mother's Name_____ Social Security #_____ Date of Birth_____

Address_____City/State/Zip_____ Home Phone_____

Mother's Employer_____ Occupation_____ Work Phone_____

Patient lives with MOTHER or FATHER or BOTH (Please circle one)

Patient's Primary Physician_____City/State_____
(if none, type none)

Referring Physician, if different_____City/State_____
(if none, type none)

Who referred you, if different?_____City/State_____

Family Members who are patients at Little Rock Allergy & Asthma Clinic_____

Type of allergy symptoms: Hay Fever/Sinus____Asthma____Hives____Other (please explain)_____

_____

Your appointment (date/time)_____

with Dr. Gene L. France / Dr. Jim M. Ingram / Dr. Karl V. Sitz / Dr Blake G. Scheer / Dr. Stacy Griffin

The undersigned consents to laboratory tests of his/her blood for the hepatitis virus and the human immunodeficiency virus (HIV) if an employee has a potential exposure through contact with the patient.

Signature of Patient or Legal Guardian_____Date_____

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GUARANTOR AND INSURANCE INFORMATION

GUARANTOR OR RESPONSIBLE PARTY

Name_____ Date of Birth_____

Social Security #_____

Address_____ City/State/Zip_____

Home Phone_____ Work Phone_____

Patient's Name (if not the same)_____

PRIMARY INSURANCE INFORMATION

Insurance Company_____ Phone_____
IF NONE, WRITE NONE

Address_____ City/State/Zip_____

Subscriber Name_____ Date of Birth_____

Social Security Number_____ Insurance effective date_____

Relationship to Patient_____

Policy ID Number_____ Group Number_____

SECONDARY INSURANCE INFORMATION

Insurance Company_____ Phone_____
IF NONE, WRITE NONE

Address_____ City/State/Zip_____

Subscriber Name_____ Date of Birth_____

Social Security Number_____ Insurance effective date_____

Relationship to Patient_____

Policy ID Number_____ Group Number_____

ACKNOWLEDGMENT AND AUTHORIZATION

I understand that as the guarantor (patient) I am financially responsible for any balance not covered under the terms and conditions of my health insurance coverage.

I authorize my insurance benefits paid directly to Little Rock Allergy and Asthma Clinic PA 18 Corporate Hill, Little Rock, Arkansas 72205.

I understand if I am unable to keep my scheduled appointment, I am asked to give at least 24 hours notice or possibly be required to pay a fee.

I authorize Little Rock Allergy and Asthma Clinic PA to release any medical or other information to my insurance company when requested.

_____ _____
Signature **Date**

_____ _____
Printed Name **Relationship to patient**

NAME:_____ AGE:_____

Date of Appointment:_____ ID (For Office Use Only):_____

New Patient History

Family Doctor:

Person Completing the form:
- ☐ Patient
- ☐ Mother
- ☐ Father
- ☐ Grandparent
- ☐ Guardian
- ☐ Health aide
- ☐ Nurse
- ☐ Other

Referred by:
- ☐ Family Doctor
- ☐ Friend
- ☐ Family member
- ☐ Self
- ☐ Another LRAA patient
- ☐ Other physician
- ☐ Other

What are your main concerns today:

- ☐ congestion
- ☐ runny nose
- ☐ post-nasal drip
- ☐ nasal itch
- ☐ eye itch
- ☐ throat clearing
- ☐ tearing eyes
- ☐ sniffing
- ☐ sinus pain
- ☐ sore throat
- ☐ sneezing
- ☐ cough
- ☐ exercise problems
- ☐ wheezing
- ☐ chest pain
- ☐ shortness of breath
- ☐ asthma
- ☐ headache
- ☐ earache
- ☐ recurrent infections
- ☐ food allergy
- ☐ eczema
- ☐ hives
- ☐ rash
- ☐ stinging insect reactions
- ☐ latex allergy
- ☐ vomiting

Other:

Medication Reaction:

Lung function tests are adjusted based on race for accuracy. Please indicate which item best describes you (the patient):

○ African-American ○ Native American ○ Asian ○ Caucasian ○ Hispanic ○ Other

Medication Name (pills, inhalers, sprays, creams, shots)	Strength/Dose	How Many	How Many Times a Day

Allergy

Are you having (allergy) eye, ear, nose, or throat problems: ○ Yes ○ No

If the above answer is NO please go to Page 4 (4th tab)

How many years have you had symptoms:
- ☐ less than 1
- ☐ 1-5
- ☐ 6-10
- ☐ 11-20
- ☐ over 20

Symptom frequency:
- ☐ daily
- ☐ weekly
- ☐ monthly
- ☐ seasonally
- ☐ rarely
- ☐ none

Please mark the items which best describe your symptoms:

Runny nose:	○ Major problem	○ Less of a Problem	○ Not a Problem
Stuffy nose/Congestion:	○ Major problem	○ Less of a Problem	○ Not a Problem
Sneezing:	○ Major problem	○ Less of a Problem	○ Not a Problem
Nasal itch:	○ Major problem	○ Less of a Problem	○ Not a Problem
Post nasal drip/throat clearing:	○ Major problem	○ Less of a Problem	○ Not a Problem
Hoarseness:	○ Major problem	○ Less of a Problem	○ Not a Problem
Discolored drainage:	○ Major problem	○ Less of a Problem	○ Not a Problem
Facial pressure:	○ Major problem	○ Less of a Problem	○ Not a Problem
Sore throat:	○ Major problem	○ Less of a Problem	○ Not a Problem
Headaches:	○ Major problem	○ Less of a Problem	○ Not a Problem
Snoring:	○ Major problem	○ Less of a Problem	○ Not a Problem
Loss of sense of smell:	○ Major problem	○ Less of a Problem	○ Not a Problem
Nosebleeds:	○ Major problem	○ Less of a Problem	○ Not a Problem
Recurring sinus infections:	○ Major problem	○ Less of a Problem	○ Not a Problem
Sniffing:	○ Major problem	○ Less of a Problem	○ Not a Problem
Sinus Pain:	○ Major problem	○ Less of a Problem	○ Not a Problem
	○ Major problem	○ Less of a Problem	○ Not a Problem

Ears

Recurring ear infections:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Itchy ears:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Ringing in ears:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Popping/Stuffy:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Hearing loss:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Balance problems:	○ Major Problem	○ Less of a Problem	○ Not a Problem

Eyes

Itchy:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Watery:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Red:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Puffy or Dark circles under eyes:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Pain:	○ Major Problem	○ Less of a Problem	○ Not a Problem
Vision Change:	○ Major Problem	○ Less of a Problem	○ Not a Problem

Please indicate if you have had any of the following treatments

If you did have the treatment, please indicate if it was helpful or not

Antihistamines (Claritin,Zyrtec, Allegra, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Decongestants (Tylenol Sinus, Sudafed, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Steroid nasal sprays (Flonase, Rhinocort, Nasonex, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Singulair:	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Non-prescription nasal sprays (Afrin, Neosynephrine, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Antihistamine nasal spray (Astepro, Astelin, Patanase):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Allergy eye drops (Pataday, Bepreve, Optivar, Patanol, etc):	○ No	○ Yes - Helpful	○ Yes - Not Helpful
Allergy shots:	○ No	○ Yes - Helpful	○ Yes - Not Helpful
If you had allergy shots, are you still on shots:	○ No	○ Yes - Helpful	○ Yes - Not Helpful

Has Patient Had:

A sinus CT scan in the past year:	○ Yes	○ No
An evaluation by an Ear, Nose, and Throat Specialist:	○ Yes	○ No
Sinus surgery:	○ Yes	○ No
Adenoids removed:	○ Yes	○ No
Tonsils removed:	○ Yes	○ No
Nasal polyps:	○ Yes	○ No
Tubes placed in ears:	○ Yes	○ No
Allergy testing:	○ Yes	○ No

☐ skin test

☐ blood work test

Nasal and/or breathing Symptoms are triggered by:

- ☐ Weather changes
- ☐ Hot humid days
- ☐ household dust
- ☐ outdoor activities
- ☐ exercise
- ☐ infections
- ☐ musty rooms
- ☐ smoke
- ☐ odors/fumes
- ☐ aspirin
- ☐ pets
- ☐ cold air

What are the worst seasons:

- ☐ year round
- ☐ spring
- ☐ summer
- ☐ fall
- ☐ winter

Food Allergy

Have food allergies been a problem: ○ Yes ○ No

Food allergy symtoms:

- ☐ hives/welts
- ☐ mouth/throat itch
- ☐ anaphylactic shock
- ☐ sneezing
- ☐ cough
- ☐ diarrhea
- ☐ wheezing
- ☐ vomiting
- ☐ eczema

Problem foods include:

- ☐ milk
- ☐ wheat
- ☐ fish
- ☐ soy
- ☐ peanut
- ☐ shellfish
- ☐ egg
- ☐ tree nut
- ☐ other

Eczema

Has eczema been a problem: ○ Yes ○ No

Eczema triggers:

- ☐ weather changes
- ☐ food
- ☐ seasons
- ☐ soap/shampoo
- ☐ clothing
- ☐ other
- ☐ none

How long has eczema been a problem:

- ☐ 0-6 months
- ☐ 7-12 months
- ☐ 1-5 years
- ☐ 6-15 years
- ☐ over 15 years

Frequency of symptoms:

- ☐ daily
- ☐ weekly
- ☐ monthly
- ☐ yearly
- ☐ occasionally
- ☐ none

Hives

Have hives been a problem: ○ Yes ○ No

Hives began:
- ☐ recently
- ☐ within the past few months
- ☐ in the past year
- ☐ years ago

Hives are associated with:
- ☐ lip swelling
- ☐ joint swelling
- ☐ bruising
- ☐ eyelid swelling

Hives appear to be triggered by:
- ☐ eating certain foods
- ☐ pain relievers
- ☐ exercise
- ☐ other medication
- ☐ infections
- ☐ cold
- ☐ not sure

Hives occur:
- ☐ daily
- ☐ weekly
- ☐ monthly
- ☐ rarely
- ☐ occasionally
- ☐ none

Hives last for:
- ☐ under 24 hours
- ☐ 1-3 days
- ☐ 1-4 weeks
- ☐ over 4 weeks

Stinging insect reactions

Have stinging insect reactions been a problem: ○ Yes ○ No

Stings causing reactions:
- ☐ ants
- ☐ bees
- ☐ hornets
- ☐ wasps
- ☐ yellow jackets

Reactions:
- ☐ swelling around the sting site only
- ☐ hives/welts
- ☐ trouble breathing
- ☐ passing out
- ☐ other

Do you have epinephrine (Epi-Pen, etc): ○ Yes ○ No

Have you ever been treated in the ER for a sting reaction: ○ Yes ○ No

Have you ever had any of the following: (Past Medical History)

☐ No known Problem

- ☐ migraine headaches
- ☐ high blood pressure
- ☐ epilepsy/seizures
- ☐ hiatal hernia/reflux
- ☐ bipolar disorder
- ☐ thyroid disease
- ☐ kidney disease
- ☐ heart disease
- ☐ osteoporosis
- ☐ fibromyalgia
- ☐ depression
- ☐ ADD/ADHD
- ☐ pneumonia
- ☐ positive TB
- ☐ glaucoma
- ☐ diabetes
- ☐ hepatitis
- ☐ HIV/AIDS
- ☐ arthritis
- ☐ cataracts
- ☐ anemia
- ☐ COPD
- ☐ ulcers

Infections:

Current Problems

Cancer:

Other:

Other:

Other:

Birth History - ADULTS SKIP TO IMMUNIZATION

Problems during pregnancy: ○ Yes ○ No

Prematureor term (weeks):
- ☐ under 26
- ☐ 26-30
- ☐ 31-36
- ☐ over 37

Lung disease: ○ Yes ○ No

required ventilation: ○ Yes ○ No

required oxygen: ○ Yes ○ No

Breast fed: ○ less than 4 months ○ 4 months or more

Formula used: ○ Milk-based ○ soy ○ other

Immunizations

Routine childhood immunizations are up to date: ○ Yes ○ No ○ I don't know

Received Pneumovax (Pneumonia vaccine): ○ Yes ○ No ○ I don't know

month / year:

Tetanus in last ten years: ○ Yes ○ No ○ I don't know

Flu shot in the past year: ○ Yes ○ No

month / year:

Tuberculosis status:
- ☐ N/A
- ☐ negative test
- ☐ treated for positive test/diseas

Medication Allergies

Current Allergies

☐ No Known Drug Allergies

Penicillin: ○ Yes

Sulfa: ○ Yes

Codeine: ○ Yes

Morphine: ○ Yes

Aspirin: ○ Yes

Ibuprofen/NSAIDS: ○ Yes

Contrast dye: ○ Yes

Cephalosporins: ○ Yes

Erythromycin: ○ Yes

Other:

Other:

Other:

Other:

Other:

Surgical History

Please indicate if you have had any of the following surgeries

	Year(s)
☐ I have had No surgeries	
☐ C-Section	
☐ Inguinal hernia - Right	
☐ Inguinal hernia - Left	
☐ Hysterectomy - Partial	
☐ Hysterectomy - Complete	
☐ Tubes Tied	
☐ Breast Surgery	
☐ Heart Bypass	
☐ Knee Surgery - Both	
☐ Knee Surgery - Left	
☐ Knee Surgery - Right	
☐ Back Surgery	
☐ Gallbladder Removal	
☐ Appendix Removal	
☐ Cataract Removal	
☐ Colectomy	
☐ Splenectomy	
☐ Tonsillectomy	
☐ Adenoidectomy	
☐ Ear Tubes	
☐ Sinus Surgery	

Other:

Other:

Other:

Other:

Other:

Other:

Family History

Mother's History:	☐ Unknown ☐ Allergies ☐ Eczema ☐ Recurrent infections ☐ Asthma ☐ Cystic Fibrosis ☐ No Problems	Father's History:	☐ Unknown ☐ Allergies ☐ Eczema ☐ Recurrent infections ☐ Asthma ☐ Cystic Fibrosis ☐ No Problems	Brother's / Sister's History:	☐ Unknown ☐ Allergies ☐ Eczema ☐ Recurrent infections ☐ Asthma ☐ Cystic Fibrosis ☐ No Problems	Son's / Daughter's History:	☐ Unknown ☐ Allergies ☐ Eczema ☐ Recurrent infections ☐ Asthma ☐ Cystic Fibrosis ☐ No Problems
Other:		Other:		Other:		Other:	

Social History

Marital Status: ○ Single ○ Married ○ Divorced/Separated ○ Widow(er)

Smoking Status:
- ○ current every day smoker
- ○ current some day smoker
- ○ former smoker
- ○ never smoker
- ○ unknown if ever smoked
- ○ smoker - current status unknown

Smoking Type: ○ Cigar ○ Cigarettes ○ Pipe

Smoking duration: ○ N/A ○ 1-5 years ○ 6-10 years ○ 11-20 years ○ Over 20 years

Maximum packs per day: ○ 1/2 ○ 1 ○ 1 1/2 ○ 2 or more

Alcohol: ○ Never ○ Rarely ○ Weekly ○ Daily

Do you primarily work: ○ Indoors ○ Outdoors

Occupation:

Other:

Pediatric Patients

Child attends: ○ Daycare ○ Preschool ○ School ○ Home school ○ None

Does child have any brothers or sisters: ○ Yes ○ No

Other:

Environmental History

Housing: ○ House ○ Apartment/Condo ○ Mobile home/Manufactured home

Foundation:
- ☐ Basement
- ☐ Crawlspace
- ☐ Slab

Air Conditioning:
- ☐ None
- ☐ Window Units
- ☐ Central

Other:

Heating:
- ☐ None
- ☐ Wood stove
- ☐ Central Hot air
- ☐ Kerosene
- ☐ Electric Space Heaters

Other:

Have you noticed mold in:
- ☐ None
- ☐ AC vents
- ☐ Bathroom
- ☐ Window frames
- ☐ Walls
- ☐ Basement

Other:

Water damage:
- ☐ None
- ☐ Leaky roof
- ☐ Plumbing problems
- ☐ Musty odors
- ☐ Condensation
- ☐ Water stains

Other:

Pets/animals (Indoor):
- ☐ None
- ☐ Birds
- ☐ Rabbits
- ☐ Cats
- ☐ Hamsters
- ☐ Guinea pigs
- ☐ Dogs
- ☐ Gerbils
- ☐ Other

Other:

Pets/animals (Outdoor):
- ☐ None
- ☐ Chickens
- ☐ Rabbits
- ☐ Cats
- ☐ Horses
- ☐ Cattle
- ☐ Dogs
- ☐ Goats
- ☐ Other

Other:

Pests:
- ☐ None
- ☐ Roaches/Waterbugs
- ☐ Mice/Rats

Other:

Tobacco smoke exposure:
- ☐ None
- ☐ Parents
- ☐ Spouse/Partner
- ☐ Grandparent
- ☐ Caretaker
- ☐ Indoor
- ☐ Outdoor

Other:

Bedroom:
- ☐ Carpet
- ☐ Hardwood
- ☐ Ceiling Fans
- ☐ Humidifier
- ☐ Sleeps in own bed
- ☐ Shares bed

Other:

Bed:
- ☐ Crib mattress
- ☐ Waterbed
- ☐ Allergy mattress cover
- ☐ Stuffed toys
- ☐ Wool blanket
- ☐ Down pillow/comforter
- ☐ Allergy pillow cover
- ☐ Standard mattress

Other:

Outdoor environment:
- ☐ None
- ☐ Construction
- ☐ Timber
- ☐ Chicken houses
- ☐ Farm

Other:

Review of Systems (Current or within the last 12 months)

General:
- ☐ No problems
- ☐ Failure to thrive
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Poor appetite
- ☐ Fatigue
- ☐ Malaise
- ☐ Weight loss
- ☐ See HPI

Heart:
- ☐ No problems
- ☐ Chest pains
- ☐ Congenital heart disease
- ☐ Palpitations
- ☐ Passing out
- ☐ Murmur
- ☐ Difficulty breathing on exertion
- ☐ See HPI

Urinary Tract:
- ☐ No problems
- ☐ Pain on urination
- ☐ Blood in the urine
- ☐ Discharge
- ☐ Urinary frequency
- ☐ Bed wetting
- ☐ Urinary infections
- ☐ Urinary stones
- ☐ See HPI

Hematologic / Lymphatic:
- ☐ No Problem
- ☐ Swollen glands
- ☐ Easy bleeding or bruising
- ☐ See HPI

months)

Skin:
- ☐ No problems
- ☐ Rash
- ☐ Suspicious lesions
- ☐ Dryness
- ☐ Itching
- ☐ Boils
- ☐ Hives
- ☐ Eczema
- ☐ See HPI

Musculoskeletal:
- ☐ No problems
- ☐ Back pain
- ☐ Bone pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Stiffness
- ☐ Arthritis
- ☐ See HPI

Neurologic:
- ☐ No problems
- ☐ Paralysis
- ☐ Weakness
- ☐ Seizures
- ☐ Passing out
- ☐ Tremors
- ☐ Dizziness
- ☐ See HPI

Gastrointestinal:
- ☐ No problems
- ☐ Heartburn/GERD
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Jaundice
- ☐ Bloody stool
- ☐ See HPI

Metabolic:
- ☐ No problems
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive drinking
- ☐ Excessive eating
- ☐ Excessive urination
- ☐ Unexplained weight change
- ☐ See HPI

Psychiatric:
- ☐ No problems
- ☐ Hyperactivity
- ☐ Behavior problems
- ☐ Depression
- ☐ Anxiety
- ☐ See HPI

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PLEASE STOP: ANTIHISTAMINES – STOP 3 DAYS (72 HOURS) BEFORE ALLERGY TESTING.

THESE DRUGS SHOULD BE STOPPED BEFORE ALLERGY TESTS:

Actifed
Advil Allergy Sinus or PM
Alavert
Allegra
Allegra-D
Antivert
Astelin Nasal Spray
Astepro Nasal Spray
Atarax
Azelastine
Benadryl
Brompheniramine
Cetrizine
Chlorpheniramine
Chlor-Trimeton
Cimetidine
Clarinex
Clarinex-D
Claritin
Claritin-D
Cyproheptadine
Dallergy
Desloratadine
Dimetapp
Diphenhydramine
Doxepin
Doxylamine
Dramamine
Dymista
Ed-A-Hist
Famotidine
Fexofenadine
Hydroxyzine
Levocetirizine
Loratadine
Meclizine
Nyquil
Patanase Nasal Spray
Pepcid
Periactin
Phenergan
Ranitidine
Robitussin Cough & Cold
Tagamet
Tavist
Triaminic Cold & Cough
Tylenol Allergy or Cold or PM
Unisom Tablets
Vazobid
Vicks Children's Cold Liquid
Xyzal
Zantac
Zyrtec or Zyrtec-D

Eye drops
Bepreve eye drops
Livostin (levocapastine) eye drops
Optivar eye drops
Pataday eye drops

THE FOLLOWING ANTIDEPRESSANTS SHOULD BE STOPPED 3 DAYS (72 HOURS) BEFORE ALLERGY TESTING (if possible and safe):

Amitriptyline (Elavil)
Adapin
Limbitrol
Nortriptyline (Pamelor)
Sinequan (Doxepin)
Triavil
Trazodone

DO NOT STOP:

1. Do not stop asthma medications. (Continue inhalers, Singulair, Accolate, Zyflo.)
2. Do not stop nose sprays (unless listed above).
3. Do not stop antibiotics and steroids. (Continue Prednisone, Prelone, Medrol or shot.)
4. Do not stop steroid or non-steroid skin creams.
5. Do not stop all other routine medications (blood pressure, diabetes, etc.).

REVISED 1/17

SPECIALIZING IN THE DIAGNOSIS & TREATMENT OF ASTHMA & OTHER ALLERGIC DISEASES IN ADULTS & CHILDREN

LITTLE ROCK ALLERGY & ASTHMA CLINIC, PA

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CLINICAL RESEARCH CENTER

RESPIRATORY THERAPY SERVICES

POLLEN COUNTS AT
www.littlerockallergy.com

Dear Valued Patient,

If you are unable to keep your appointment, you are asked to provide timely notice for cancellations prior to your appointment time. Unfortunately, in recent years "No Show" rates for appointments have increased. If a patient does not keep a scheduled appointment or does not reschedule prior to 24 hours, it will be considered a "No Show". This creates challenges in scheduling and compromises our ability to provide timely care to all patients needing appointments.

Therefore, effective April 12, 2018, Little Rock Allergy & Asthma Clinic will be implementing a formal policy that states if a patient has 2 "No Show" appointments they will be required to pay a $50.00 deposit before the next appointment is scheduled. The $50.00 deposit will be applied to patient charges if the appointment is kept. If the appointment is not kept and results in a "No Show", the $50.00 will be applied to the account to cover the fee for that missed appointment.

Thank you for keeping your scheduled appointments, and when needed, rescheduling in a timely manner.

_____ _____

Signature Date