WELCOME!

We are honored that you have chosen **Northwest Asthma & Allergy Center** to become a member of your healthcare team. We look forward to caring for you and/or your family. Our providers are trained and experienced in the treatment of asthma, allergies, eczema, hives, and immune system disorders for both children and adults.

We strive to make your visit a pleasant one and make every effort to be timely. Your appointment time has been reserved exclusively for you. Therefore, we respectfully request that you notify us as soon as possible if you are unable to keep your scheduled visit. Please note that a **minimum of 24 hours** is required to avoid the late cancellation/no show fee. (*See our attached Financial Policy*.) If you are late for your appointment, we may ask you to reschedule to another day.

We highly encourage you to call your insurance company to verify your allergy benefits along with any limitations you may have on your policy.

We **require that a parent or legal guardian** be present for the initial new patient appointment. We understand that there may be extenuating circumstances that make this difficult so please notify us ahead of time. Foster parents must provide legal documentation showing they have authorization from the state to obtain healthcare, including allergy testing.

Please use the checklist below to ensure that we will have all the information needed for your initial evaluation.

We look forward to meeting you!

- ☑ **3 days before your appointment:** Please discontinue antihistamines to allow for skin testing. See Table on the back. If your condition is bothersome enough to prevent you from stopping antihistamines for the suggested time period, we ask that you keep your scheduled appointment to discuss alternative medications or testing options.

  DO NOT STOP asthma medications such as asthma pills (montelukast/Singulair), inhalers, prednisone/prednisolone/methylprednisolone or other steroid medications.
  DO NOT DISCONTINUE antidepressants or psychotropic medications without consulting with your prescribing physician.
- ☑ **1 day before your appointment:** Please discontinue histamine blocking reflux medications.
- ☑ **Please arrive 30 minutes** prior to your scheduled appointment time to complete paperwork.
- ☑ Allow 1-1/2 to 2 hours for a New Patient appointment.
- ☑ Bring your photo ID such as driver's license or identification card, insurance card, co-pay, and credit card to keep on file.
- ☑ Bring a current list of all prescription medications, over-the-counter medications, and supplements with the dosages that you take.
- ☑ Bring a copy of any relevant medical records with you such as hospital records, previous allergy testing, radiology and/or laboratory results.
- ☑ Bring address and telephone number of your referring doctor or primary care physician.
- ☑ Wear comfortable clothing to allow for skin testing. This is generally done on the forearms, upper arms, or the back.
- ☑ Northwest Asthma & Allergy Center is fragrance-free. We kindly ask you to refrain from wearing any perfume or scented products to your appointment.
- ☑ Please do not eat/snack while in the office.

WHEN TO STOP MEDICATION BEFORE TEST	NAME OF MEDICATION
10 days	Oral antihistamines • Cyproheptadine (Periactin) • Hydroxyzine (Atarax, Vistaril)
3-7 days	Nasal spray and/or eye drop antihistamines • Azelastine (Astelin, Astepro, Dymista) • Olopatadine (Pataday, Patanase, Patanol) Oral antihistamines (can be in cold/flu/sleep medications) • Acrivastine (Semprex-D) • Brompheniramine (in combination products) • Carbinoxamine (Dimetapp, Palgic, Rondec) • Cetirizine (Zyrtec, Wal-Zyr, Allertec, etc.) • Chlorpheniramine (Chlor-Trimetron, Triaminic, etc.) • Clemastine (Tavist) • Desloratadine (Clarinex) • Diphenhydramine (Benadryl, Nyquil, may end in -PM) • Fexofenadine (Allegra, Allerfex) • Levocetirizine (Xyzal) • Loratadine (Alavert, Allerclear, Claritin, etc.) • Pheniramine Motion sickness pills: • Cyclizine (Marezine, Nausicalm,Valoid, etc.) • Meclizine (Antivert, Bonine, Dramamine) Anti-nausea pills: Promethazine (Phenergan)
24 hrs	Certain anti-reflux medications (which are antihistamines) • Cimetidine (Tagamet) • Famotidine (Pepcid) • Ranitidine (Zantac)

PLEASE CALL OUR OFFICE IF YOU HAVE ANY QUESTIONS

NORTHWEST ASTHMA & ALLERGY CENTER (NAAC)
NOTICE OF PRIVACY PRACTICES & FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT (Effective 12/1/17)

NOTICE OF PRIVACY PRACTICES

Northwest Asthma & Allergy Center (NAAC) has a responsibility to protect the privacy of your health care information. We maintain a record of the healthcare services we provide you. We will share this information, as permitted by law, to provide and coordinate your medical treatment, bill for these services, and conduct usual health care operations. You have the right to review, obtain a copy, or request to amend the record if needed.

Our ***Notice of Privacy Practices*** describes in more detail your rights to your health information and how this information may be used and disclosed. Sharing of your health information is typically used to improve the continuity of care that you receive. Common examples include accessing prescription history for pharmacy benefits, discussing an opportunity to enroll you in clinical research studies with our non-profit research affiliate, ASTHMA, Inc. and/or participating with Health Information Exchanges (HIE) with other health care organizations to improve quality, safety and efficiency of health care. We may change the Notice of Privacy Practices at any time; a current copy is found on our website: www.nwasthma.com or you may contact our Privacy Officer for additional questions or concerns.

FINANCIAL POLICY

1. ***Payment for all medical care is the patient's responsibility regardless of insurance coverage.***

2. Patient Information/Proof of Insurance: At each visit, please be prepared to present your insurance card as proof of insurance.

3. Insurance: We participate in most insurance plans and will submit claims on your behalf to the insurance company. **Knowing your insurance benefits and rules is your responsibility**. We highly encourage you to call to verify your own benefits along with any limitations you may have on your policy. If your plan has limitations, it is your responsibility to share these limitations with the provider prior to having any procedures performed. If your insurance company requires a specialist referral from your primary care physician, it is your responsibility to obtain that referral prior to scheduling your appointment. Referrals (including allergy shots, biologic treatments, and procedures) must be up-to-date and on file prior to all appointments. You will be responsible for any charges resulting from an out-of-date referral.

4. Co-payments and deductibles: **Co-pays must be paid at the time of service**. Parent or adults accompanying a minor will be responsible for the patient's co-pay and bill at that visit.

   If insurance discloses that there is an unfulfilled deductible over $300 for a new patient or over $150 for an established patient, you may be required to make a minimum down payment of $300 at the initial visit or $150 at the established visit. The remaining balance will be due at the time of receipt of your invoice (billing statement).

5. Non-covered services: Our providers follow appropriate medical guidelines for standards of care based on your medical condition. Please be aware that some of the services you receive may be determined by your insurance plan to be only partially covered or not covered. **You will be responsible for the cost of services that is not paid by insurance.**

6. Claims submission: We will bill your insurance company on your behalf. You are responsible to know your own insurance benefits. Coverage, co-payments, co-insurance and deductibles can change on an annual basis. If there is a change in your insurance coverage, please notify the clinic as soon as possible. Some insurance companies have time limits on when claims need to be submitted. If we do not have the correct information, we cannot file the claim in a timely manner.

7. Account balances: All account balances are due upon receipt of your billing statement. If the account remains unpaid after 90 days, it will be referred to a third party collector. Failure to pay the account balance may result in discharge from the practice, including family members who are also patients. In such case, you may request that your medical records be transferred to another provider at no charge. If, after being discharged, you would like to be considered for reinstatement to the practice, all financial obligations must be paid in full. Reinstated patients are required to maintain a credit card on file.

8. Method of Payment: We accept cash, checks, and credit cards including: American Express, Discover, MasterCard or Visa.

9. Returned checks: Any non-sufficient fund checks will be charged a $35 fee.

10. Credit Card On File: We encourage patients to keep a credit card on file to make the checkout process easier, faster, and more efficient. After your insurance has paid its portion of your bill, we will notify you via e-statement of the balance owed, charge your credit card the balance owed 31 days after you receive your e-statement, and send a receipt for the charged amount. Credit card numbers are encrypted and stored securely off-site. No credit card numbers are stored at our practice. All Private Pay patients are required to have a credit card on file or they will not be scheduled or seen for an appointment.

11. Telephone service: If you request medical services via telephone instead of a visit to our office including after hours, you may incur telephone service fees. This will be billed to your insurance company but may not be a covered service. You must be an established patient to request this service. If the phone visit is pertaining to an office visit within the previous 7 days or results in an office visit within 24 hours or next available urgent visit, you will not be charged for telephone service.

12. Late cancel and no-show appointments: **If you arrive late (≥15 minutes) for your appointment, you may be asked to reschedule to another day. Late cancel (≤ 24-hours notice) and no-show appointments incur a $75 fee; for vocal cord dysfunction appointments, the fee is $150.** New patients who miss their first appointment will be required to keep a credit card on file with us for their first visit via credit card swipe at our electronic kiosk. If a patient late cancels or no shows twice within a 12-month period, s/he and other family members will be discharged from the practice. When you make an appointment, **it is your responsibility to attend the appointment or give us 24-hour notice for cancellation or rescheduling**. **Our text and email reminders are a courtesy.**

13. Divorce/Separation: In cases of divorce and/or separation, the legal guardian and/or the person completing paperwork and/or bringing the child in for the **initial** visit will be considered the Guarantor and will be held responsible for paying any medical services. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

I have reviewed a copy of the Notice of Privacy Practices which provides information about how my health information may be used and disclosed. I have read and understand the Financial Policy of Northwest Asthma & Allergy Center (NAAC). I assign payment from my insurance directly to NAAC. I understand that I am financially responsible to NAAC for the charges not paid by insurance and that those charges are due upon receipt of invoice (billing statement).

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that NAAC participates in the training of physicians and other healthcare providers and consent to their involvement. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed at or by NAAC.

Patient/Guarantor Signature	Date	
Printed Name of Signature Above	Relationship to Patient	
Patient's Name	Date of Birth	Acct # (office use)
Patient's Name	Date of Birth	Acct # (office use)
Patient's Name	Date of Birth	Acct # (office use)
Patient's Name	Date of Birth	Acct # (office use)

NORTHWEST ASTHMA & ALLERGY CENTER

Authorization for Health Care of a Minor Child without a Parent or Legal Guardian Present

Child's Name: _____ Patient Date of Birth: _____

Child's Name: _____ Patient Date of Birth: _____

Child's Name: _____ Patient Date of Birth: _____

Child's Name: _____ Patient Date of Birth: _____

Child's Name: _____ Patient Date of Birth: _____

This form may be used to allow a minor child to receive treatment at our facility without a parent or legal guardian present. **Routine medical care will not be provided to a minor without consent by the parent, legal guardian or authorized person(s) indicated below.** The Authorization portion below would allow another adult to serve as a proxy decision maker for routine medical care and services. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or emergent care being required.

AUTHORIZATION

Please check applicable option below for authorization of treatment:

- ○ I decline (non-emergency) treatment of my child if I am not present.
- ○ I, the parent or legal guardian of the minor(s) listed above, authorize the patient who is 16 years or older to come in by her/himself for recheck/sick appointments and/or allergen immunotherapy (allergy shots).
- ○ I, the parent or legal guardian of the minor(s) listed above, hereby authorize the person(s) listed below to make health care decisions for my minor child(ren). I give permission to Northwest Asthma & Allergy Center to provide medical care and interventions which may include, but are not limited to: medical evaluation, physical exam, allergy skin testing, pulmonary function testing, any oral/intramuscular/intravenous medications, immunizations, allergen immunotherapy (allergy shots), x-rays, and lab work, pursuant to the consent of proxy or without proxy consent if medically necessary on an emergent basis, at the physician's discretion. I also agree for my minor child(ren) to have additional emergency care if warranted, to include utilization of 911 system, emergency room care and/or hospitalization.

  I understand all co-pays must be paid at the time of service. I also understand whoever brings my minor child(ren) in will be expected to present valid identification and copies of insurance cards. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization.

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

Limitations:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none").

☐ NONE

_____

_____

Parental contact information for questions regarding treatment:

Name	Cell Phone #	Alternative Phone #
	☐	☐
	☐	☐

By checking the box(es) next to the numbers listed above, I give my permission for NW Asthma & Allergy Center to leave detailed medical information at these telephone numbers.

In the event an urgent or emergent medical situation arises that requires an immediate medical intervention (e.g. treatment of an allergic reaction to allergen immunotherapy [allergy shots]) and the parent, assigned proxy and/or legal guardian is not present, NAAC will treat the minor child as deemed necessary by our provider(s) and staff. We will contact the parent/legal guardian/proxy in a timely fashion to notify them of the clinical situation, the minor child's status, and intervention performed and rationale for the urgent medical intervention. This authorization is valid until the minor child's 18th birthday, unless revoked in writing by the undersigned, or a new form is completed. Only one parent signature is required.

_____ _____

Signature of Parent or Legal Guardian Date

Annual Updates (office staff to print, have patient review/make changes, initial and date annually)

INITIALS_____ Date:_____ Reviewed and ☐ Changes made or ☐ Correct as is

INITIALS_____ Date:_____ Reviewed and ☐ Changes made or ☐ Correct as is

INITIALS_____ Date:_____ Reviewed and ☐ Changes made or ☐ Correct as is

INITIALS_____ Date:_____ Reviewed and ☐ Changes made or ☐ Correct as is

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INITIALS_____ Date:_____ Reviewed and ☐ Changes made or ☐ Correct as is

INITIALS_____ Date:_____ Reviewed and ☐ Changes made or ☐ Correct as is

NORTHWEST ASTHMA & ALLERGY CENTER, P.S.

Informant: ☐ **Patient** ☐ **Parent** ☐ **Relative**

PATIENT HISTORY

DOCTORS NOTES

DESCRIBE YOUR SYMPTOMS

1.
2.
3.

Other health concerns: _____

Onset of problem: ☐**infancy** ☐**childhood** ☐**teens** **age** _____ **or year** _____

Areas lived: _____ _____ _____ **Time in Northwest:** _____

AREAS AFFECTED: ☐**Eyes** ☐**Ears** ☐**Nose** ☐**Throat** ☐**Lungs** ☐**Digestive** ☐**Skin**

SYMPTOMS: ***(circle ALL that apply)***

☐ Itching/Red/Tearing Eyes
☐ Ear Popping/Plugging
☐ Headache
☐ Sneezing
☐ Runny Nose
☐ Congestion
☐ Snoring
☐ Postnasal Drip
☐ Throat Clearing
☐ Infection
☐ Bad Breath
☐ Cough
☐ Bronchitis
☐ Tightness
☐ Wheezing
☐ Shortness of Breath
☐ Abdominal Pain
☐ Heartburn
☐ Vomiting
☐ Diarrhea
☐ Hives
☐ Swelling
☐ Rash
☐ Eczema

WHAT FACTORS CAUSE OR WORSEN SYMPTOMS?: *(circle ALL that apply)*

☐Spring ☐Summer ☐Fall ☐Winter
☐Outside ☐In House ☐Daycare ☐School ☐2nd Home
☐Cats ☐Dogs ☐Feathers/Down
Other Animals: _____
☐Tree ☐Grass ☐Weeds ☐Mold/Mildew ☐Dust
☐Cold Air ☐Heat ☐Exercise
☐Colds/Upper Respiratory Infections
☐Smoke/Pollution ☐Fumes/Chemical Odors
☐Weather Changes
☐Sun ☐Soaps/Detergents ☐Cosmetics ☐Clothing

Insect Stings: ☐Sting ☐Bite Type of reaction: _____

Drug Reactions: ☐Antibiotics ☐Aspirin ☐Other Anti-inflammatory (e.g., ibuprofen, naproxen, etc)

Type of reaction: _____

Foods: _____

Latex reactions: _____

PREVIOUS ALLERGY EVALUATION AND MEDICATIONS PRESCRIBED:

When? _____ Where? _____ MD? _____ Skin tests? _____

Treatments Tried: _____ Pills: _____

Nasal sprays: _____ Inhalers: _____

Allergy shots - Years: _____ Steroids (prednisone): _____

CURRENT AND "AS NEEDED" MEDICATIONS from all physicians (including over-the-counter products like aspirin, antihistamines, and vitamins): _____

DRUG ALLERGIES: _____

PAST MEDICAL HISTORY:

Hospitalizations: _____ ER visits: _____

Surgery: _____ Immunization up to date?: ☐Yes ☐No

CHRONIC MEDICAL PROBLEMS, PAST AND PRESENT: *(circle ALL that apply)*

☐Cancer (type_____)
☐Diabetes
☐Ear Infections
☐Epilepsy/Seizures
☐GERD (acid reflux)
☐Heart Disease
☐Hepatitis
☐High Blood Pressure
☐Kidney Disease
☐Migraine Headaches
☐Osteoporosis
☐Pneumonia
☐Positive Tuberculin Test/TB
☐Sinus Infections
☐Thyroid Disease
☐Ulcers

☐Other _____

FOR CHILDREN < 2 YRS.:

Birth History: Birth Weight: _____ Complications: _____

Breast Feeding: _____ Formula (type): _____

TURN OVER PLEASE ➔➔➔

FAMILY HISTORY:

	Nasal Allergy	Asthma	Skin Allergy	Food Allergy	Other:
Mother	☐	☐	☐	☐	☐ _____
Father	☐	☐	☐	☐	☐ _____
Brother	☐	☐	☐	☐	☐ _____
Sister	☐	☐	☐	☐	☐ _____
Daughter	☐	☐	☐	☐	☐ _____
Son	☐	☐	☐	☐	☐ _____

SOCIAL HISTORY:

Marital status: ☐ Single ☐ Married / Partner ☐ Divorced ☐ Widowed

For Children <18 yrs: # of siblings _____ ☐ daycare ☐ preschool ☐ school ☐ home school

Current occupation: _____ Hobbies _____

☐ Cigarette/☐ E-cig ☐ Marijuana ☐ Cigars ☐ Chew Tobacco: *Current-How much per day?* _____

Started when? _____ Attempts to quit? _____

Past - How much/day? _____ When did you quit? _____

Alcohol use - Drinks/day: _____ Drug use: _____

ENVIRONMENTAL HISTORY:

Current Home ☐ house ☐ condo ☐ apartment ☐ mobile home ☐ new ☐ old ☐ remodel How old?

☐ city ☐ rural ☐ suburban ☐ country ☐ own ☐ rent How long here?

Outdoor factors: ☐ trees ☐ fields ☐ swamps ☐ Other

Heat/Ventilation: ☐ forced air (furnace/heat pump) ☐ radiant ☐ baseboard ☐ wood stove/fireplace ☐ space heater

☐ air conditioner (window/central) ☐ wall units ☐ radiator

Filter? ☐ None ☐ fiberglass ☐ HEPA ☐ electrostatic ☐ air cleaner; How often changed/cleaned? _____ Ducts cleaned? _____

Mold/Mildew: ☐ basement ☐ laundry ☐ kitchen ☐ bath humidifier / dehumidifier

Rooms with carpeting: ☐ bedroom ☐ living room ☐ TV room How old? _____

Patient's Bedroom: *Mattress* ☐ regular ☐ foam ☐ futon ☐ waterbed ☐ air mattress How many stuffed toys?

Pillows: ☐ regular ☐ foam ☐ feater/down ☐ synthetic *Comforter:* ☐ cotton ☐ feather/down ☐ synthetic

Pets: How many? ☐ Cat(s) _____ ☐ Dog(s) _____ ☐ Other: _____

Smokers in home: ☐ none ☐ patient ☐ mother ☐ father ☐ spouse/partner ☐ child packs/day: _____

REVIEW OF SYSTEMS

Do you CURRENTLY have or have you RECENTLY had any of the following? Circle "none" if negative.

☐ none	**General**	☐ fatigue	☐ fever	☐ night sweats		
☐ none	**Eyes**	☐ blurry vision	☐ itchy eyes	☐ red eyes	☐ tearing	☐ change in vision ☐ glaucoma
☐ none	**ENT**	☐ hearing loss	☐ ringing in ears	☐ nose bleeds	☐ nasal drainage	☐ sinus problems
		☐ fever	☐ sore throat	☐ hoarseness	☐ snoring	☐ loss of smell ☐ nasal polyps
☐ none	**Respiratory**	☐ cough	☐ shortness of breath	☐ wheezing	☐ history of pneumonia	
☐ none	**Heart**	☐ chest pain	☐ foot swelling	☐ heart murmur	☐ fast heart rate	☐ palpitations
☐ none	**Digestive**	☐ abdominal pain	☐ constipation	☐ heartburn / indigestion	☐ nausea	
		☐ vomiting	☐ diarrhea	☐ blood in stool		
☐ none	**Skin**	☐ acne	☐ dry skin	☐ itching	☐ rash	☐ sores
		☐ hives	☐ swelling	☐ hair loss	☐ psoriasis	
☐ none	**Musculoskeletal**	☐ joint swelling	☐ joint pain	☐ muscle aches	☐ back pain	☐ arthritis
☐ none	**Neurological**	☐ behavior problems	☐ learning problems	☐ daytime sleep	☐ dizziness	
		☐ fainting	☐ headache/migraines	☐ seizures	☐ memory loss	
☐ none	**Endocrine**	☐ cold intolerance	☐ heat intolerance	☐ excessive thirst	☐ weight gain or loss	
☐ none	**Blood/Lymph**	☐ anemia	☐ swollen lymph node	☐ unusual bleeding or bruising		
☐ none	**Urinary**	☐ painful urination	☐ frequent urination	☐ frequent infections		
☐ none	**Psych/Social**	☐ anxiety	☐ depression	☐ drug/alcohol	☐ stress	☐ sleep problems
☐ none	**Reproductive**	☐ pregnancy	☐ planning pregnancy?	☐ fertility problems		

Reviewed with patient by MD _____ **Date** _____

Northwest Asthma & Allergy Center, P.S.

General Patient Information

This information will be considered confidential and is necessary for our files.

Date:___/___/_____

Patient's Last Name _____ First Name _____ Middle Name _____ Sex: ☐ Male ☐ Female

Mailing Address _____

City _____ State _____ Zip _____

Patient's Age: _____ Date of Birth: _____
Month / Day / Year

Employer: _____

Race:

☐ Declined ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian
☐ Multi-racial ☐ Native American ☐ Pacific Islander ☐ Chinese ☐ Filipino
☐ Undetermined ☐ Native Hawaiian ☐ Native Hawaiian ☐ Japanese
☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Declined

Best Daytime Phone #: Please Circle One:
(____) _____ - _____ (Mobile, Home or Work)
Check one: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Alternate Phone #:
(____) _____ - _____ (Mobile, Home or Work)
Check one: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Email Address: _____

Emergency contact person outside of the home:
_____
Name Phone # Relationship to Patient

1. Do you have other family members who are seen by our providers? If so, list name(s) & their relationship to the patient.

☐ No ☐ Yes: _____

2. Were you referred to us by a healthcare provider?

☐ No ☐ Yes: _____
Doctor's First and Last Name Address Phone and / or Fax

3. Would you like your visit sent to your primary care provider? Please state title, such as: MD, ARNP, DO, ND.

☐ No ☐ Yes, same as above.

☐ Yes, different: _____
Doctor's First and Last Name Address Phone and / or Fax

Insurance Information

Primary Insurance Company Name: _____

ID #: _____ Insurance Address: _____
Street City, State Zip Code

Group or local #: _____

Subscriber's name: _____ Employer of Subscriber: _____
(As It Appears on Insurance Card)

Subscriber's Date of Birth: _____ Subscriber's relationship to Patient: ☐ Self ☐ Spouse ☐ Other: _____
Month / Day / Year

Secondary Insurance: ☐ No ☐ Yes: _____

ID #: _____ Insurance Address: _____
Street City, State Zip Code

Group or local #: _____

Subscriber's name: _____ Employer of Subscriber: _____
(As It Appears on Insurance)

Subscriber's Date of Birth: _____ Subscriber's relationship to Patient: ☐ Self ☐ Spouse ☐ Other: _____
Month / Day / Year

Assignment of Insurance Benefits / Consent to Care

I authorize payment of medical benefits to the providers of Northwest Asthma & Allergy Center. I also authorize the release of any medical record information necessary to process the insurance claim. I understand that regardless of insurance coverage, I am responsible for my account and any balances due. I further give consent for me/my child to be evaluated and treated by Northwest Asthma & Allergy Center. The above information is accurate and complete to the best of my knowledge.

Patient's or Guarantor's Signature _____ Relationship to patient: ☐ Self ☐ Parent / Legal Guardian ☐ Other: _____

Print Name of Signature Above _____ Guarantor's Date of Birth: _____

12.5.17

Northwest Asthma & Allergy Center, P.S.

Please see our website for detailed directions: www.nwasthma.com
Do not use GPS, Google or Mapquest where noted below, as it will take you to the wrong place

Clinic Locations

Everett
Silver Lake Pavilion
10333 – 19th Ave SE, Suite 105
Everett, WA 98208

Phone: 425.385.2802
Fax: 425.337.7967

Issaquah
22605 SE 56th St, Suite 270
Issaquah, WA 98029

Phone: 425.395.0175
Fax: 425.395.0176

Please note: From E. Lake Sammamish Parkway, we are the 4th entrance on the RIGHT side of the street (going east, up the hill). Go PAST the entrance for 24 Hour Fitness and the Goddard School. We're in the Sammamish View Building, just before the crest of the hill, across the street from the Park Hill Apartments. Look for our white sandwich sign at the driveway.

Redmond
8301 – 161st Ave NE, Suite 308
Redmond, WA 98052

Phone: 425.885.0261
Fax: 425.883.8474

Renton
IDC Building
1412 SW 43rd St, Suite 210
Renton, WA 98057
(do NOT use GPS/Google/Mapquest)

Phone: 425.235.1716
Fax: 425.277.5479

Richland
108 Columbia Pt Dr
Richland, WA 99352

Phone: 509.946.0189
Fax: 509.946.0264

Seattle
Northgate Executive Center II
9725 – 3rd Ave NE, Suite 500
Seattle, WA 98115

Phone: 206.527.1200
Fax: 206.523.0724

Yakima
3901 Creekside Loop, Suite 100
Yakima, WA 98902

Phone: 509.966.3259
Fax: 509.966.0191

Seattle Allergy & Asthma
RESEARCH INSTITUTE

Are You Interested in Learning More About Allergy and Asthma Related Research Studies?

The physicians at Northwest Asthma and Allergy Center (NAAC) have maintained a longstanding commitment to clinical research studies. Since 1972, the NAAC physicians have been involved in more than 500 US Food and Drug Administration (FDA) approved clinical trails through their nonprofit research affiliate called Seattle Allergy & Asthma Research Institute, formerly known as ASTHMA, Inc. SAARI is located in the Northgate office and is currently enrolling for multiple allergy and asthma clinical studies.

SAARI and NAAC are also members of Seattle Food Allergy Consortium (SeaFAC). To learn more about our upcoming clinical food allergy trials, please visit the website at www.seattleallergy.org.

If you are interested in learning more, please list your telephone number and/ or email address, so we may contact you.

Name: _____

Telephone number: _____

Email Address: _____

For more information, please check out our website at:

www.seattleallergy.org

www.seafac.org

Northgate Executive Center II
9725 Third Avenue NE, Suite 500
Seattle, WA 98115
Phone: 205-525-5520 • Fax: 206-524-6549 • www.SeattleAllergy.org
Associated with Northwest Asthma & Allergy Center