M.H.V. STRICKLAND M.D.

10021 W. 21ST STREET NORTH

WICHITA KS 67205

316-722-4800 PHONE 316-722-5117 FAX

We appreciate the confidence you have shown in us by choosing to become an active, informed member of a health care team dedicated to your well-being. We will do our best to treat your health care needs with concern, compassion and respect.

In order to make your first visit go as smoothly as possible please have all paperwork completed prior to your first visit, if necessary, we will be happy to mail the new patient paperwork to you. Please bring completed forms, driver's license, insurance card and payment if due to your initial visit.

Your initial appointment may take approximately three hours. It generally includes a review of your medical history, testing if necessary and a treatment plan.

Please discontinue taking any type of antihistamines 48 hours prior to your appointment. Also it is important to notify the office in advance if you are taking Beta Blockers. It would be helpful to bring a list of medications along with any test or lab work that may have previously been done.

As a courtesy we will call and remind you of your initial appointment. Due to the block of time that has been scheduled for your initial visit, if we are unable to reach you, we require you call and confirm no later than 48 hours prior to your appointment. If you are unable to keep your appointment, please let us know as soon as possible.

Due to our practice serving highly allergic people, please do not wear perfume, cologne or essential oils to the office. Also please no food or drink in consideration of our food allergic patients. Your understanding and cooperation is appreciated. We want to make your experience in our office as pleasant as possible. If you have any concerns, questions or special needs please do no hesitate to discuss them with us.

We look forward to seeing you and thank you for choosing M.H.V. Strickland M.D. for your healthcare needs.

M.H.V. Strickland M.D
Office Policies

We appreciate the confidence you have shown in us by choosing to become an active, informed member of a health care team dedicated to your well being. We will do our best to treat your health care needs with concern, compassion and respect. Your clear understanding of our financial policy is important to our professional relationship.

Our office requires 24 business hours notice for appointment cancellations. Otherwise, the patient may be charged a $25 No Show fee for the missed appointment.
Initial: _____

Initial appointments scheduled with M.H.V. Strickland M.D. require 48 business hours notice for appointment cancellation/rescheduling. If 48 business hours notice is not provided, the appointment may not be rescheduled.
Initial: _____

It is the patient's responsibility to know the date and time of his/her appointment. Appointment reminder calls are a courtesy.
Initial: _____

The office will verify the patient's health benefits; however, this is not a guarantee of payment. It is the patient's responsibility to know his/her benefits including deductibles, co-pays and visit limitations. In addition, it is the patient's responsibility to obtain a **current referral** and keep track of visits used during his/her benefit year.
Initial: _____

Co-pays/coinsurance are due at the time of service. Patient balances not received within 30 days of the visit may be subject to a late fee.
Initial: _____

Please notify our office in a timely manner of any changes, including: insurance coverage, address and telephone number. Delay in providing us with accurate insurance information may prevent insurance reimbursement, and the patient will be responsible for fees.
Initial: _____

Our office submits claims ONLY to the insurance companies with whom we are contracted.
Initial: _____

There will be a $30 charge for any returned checks. If there is a history of 2 returned checks, our office will ONLY accept cash, money order or credit card payments.
Initial: _____

If the balance of your account or previously agreed upon payments are not received in a timely manner, you will receive a final notice requesting immediate payment. If payment still is not received, your account will be turned to a collection agency, and you will be assessed any collection costs incurred, and you will then be advised to obtain a new healthcare provider. If your collection suit is referred to an attorney, you will be assessed all lawyer fees incurred in addition to court costs.

Print Patient Name:_____

Signature: _____ **Date:** _____
(Parent/Guardian if patient is a minor)

M.H.V. Strickland M.D.
Patient Information

☐ New Patient
☐Update Only

Patient Information
(Fill Out Completely)

Date_____
Account #_____

☐ Male ☐ Female

Legal Name_____ SSN___/___/____ DOB___/___/_____
Last First MI

Physical Address_____ Apt#_____ City_____ State____ Zip_____

Mailing Address_____ City_____ State____ Zip_____
(If Different From Physical)

Home Phone_____ Work Phone_____ Cell Phone_____

Marital Status_____ Spouse_____

Primary Care Physician_____ Phone No._____

Responsible Party Information (For Billing) ☐ Same as Patient

Name_____ DOB___/___/_____ SSN___/___/_____

Address_____ Apt#_____ City_____ State_____ Zip_____

Relationship to Patient_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employment Status: ☐ FT ☐ PT Employer_____ ☐ Not Employed

Primary Insurance	Secondary Insurance
Ins Name_____	Ins Name_____
Effective Date_____	Effective Date_____
Insurance ID#_____	Insurance ID#_____
Policy Holder_____	Policy Holder_____
Date of Birth_____	Date Of Birth_____

Emergency Contact Information	Emergency Contact Information
Legal Name_____	Legal Name_____
Address_____	Address_____
Home Phone_____ Cell Phone_____	Home Phone_____ Cell Phone_____

M.H.V. Strickland M.D.

PATIENT RESTRICTION OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

Home/Cell Phone
☐ OK to leave message with detailed information
☐ Leave message with call back number ONLY

Work Phone
☐ OK to leave message with detailed information
☐ Leave message with call back number ONLY

Written Communications
☐ OK to mail to my home address
☐ OK to mail to my work/office address

Other
_____

PATIENT DISCLOSURE PREFERENCES

You are hereby authorized to furnish any or all medical and insurance information concerning my medical/physical condition and test results with the following:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

- I understand my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim.
- I have received and agreed to M.H.V. Strickland M.D. office policies.
- The above information is accurate to the best of my knowledge.

Patient's Signature: _____ **Date:** _____

Parent/Guardian Signature if minor: _____ **Relationship to patient:** _____

M.H.V. Strickland M.D.

AUTHORIZATION TO DISCLOSE MEDICAL RECORD INFORMATION TO PRIMARY CARE PHYSICIAN

Patient's Name: _____

Patient's Date of Birth: _____

I, _____ authorize M.H.V. Strickland M.D. PA
(Patient/Legal Guardian, if minor)
to disclose the following information in order to coordinate treatment: All medical records including labs and testing.

Primary Care Physician: _____

Located at the following address: _____

_____

Phone_____ Fax _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

_____ _____
(Signature of Patient/Legal Guardian, if minor) (Date)

_____ _____
(Witness) (Date)

I DO NOT WISH TO AUTHORIZE RELEASE OF INFORMATION

_____ _____
(Signature of Patient/Legal Guardian, if minor) (Date)

M.H.V. Strickland M.D.

NEW PATIENT HISTORY SHEET
COMPLETE THE FOLLOWING INFORMATION

I. Personal Data:

Name_____ Date of Birth_____ M or F

Address_____ City_____ St____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

II. Major Allergy Symptoms:

a. What type of allergy symptoms do you have? _____

b. How long have you had these problems and how frequently do you have them?

_____

c. Are you being treated for any other medical problems? _____

If so by whom? _____

d. What medications do you take? _____

e. Have you ever been tested by any means for allergies? _____

If so, were you on allergy injections? _____ How long? _____

f. Have you ever had an allergic reaction to medications or drugs? _____

If so, which medications? _____

III. Symptoms

A. Please circle all that apply to the following questions:

1. Do you seem to have problems more in the: ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ All?

2. Did your problems begin: ☐ Suddenly or ☐ Gradually?

3. Are your problems worse in the: ☐ Morning, ☐ Afternoon, or ☐ Night?

4. Which parts of the body are more affected by your allergy problem:
   ☐ Head ☐ Eyes ☐ Nose ☐ Throat
   ☐ Ears ☐ Chest ☐ Skin ☐ Intestinal

5. Are your symptoms affected by:
   ☐ Dust ☐ Pollens ☐ Animals ☐ Feathers
   ☐ Mold/Mildew ☐ Smoke ☐ Time of Year ☐ Strong Odors
   ☐ Food/Diet ☐ Time of Day ☐ Air-Conditioning ☐ Weather Changes

B. Family History:

1. Has anyone in your family had Asthma, Allergies, Hay fever or Sinus problems?
   ☐ Mother ☐ Father ☐ Brothers/Sisters ☐ Other Relatives_____

2. Is there a history of any other serious medical problem? _____

Allergy Questionnaire

GENERAL

1. Are you bothered by fatigue, depression or "nerves"?	YES	NO
2. Are you very irritable	YES	NO
3. Do you have frequent mood changes?	YES	NO
4. Do you have loss of energy, feel tired or fatigued?	YES	NO
5. Do you have poor attention or behavior problems in school or work?	YES	NO
6. Do you have hives, eczema or other skin rashes?	YES	NO

RESPIRATORY

1. Do you have a "stuffy", "runny" or "itchy" nose?	YES	NO
2. Do you have sneezing?	YES	NO
3. Do you have itchy, watery, dry or red eyes?	YES	NO
4. Do you have postnasal drip?	YES	NO
5. Do you have headaches?	YES	NO
6. Are you bothered with "sinus" problems?	YES	NO
7. Do you have pressure, popping or fullness in your ears?	YES	NO
8. Do you have recurrent ear infections?	YES	NO
9. Do you have frequent "colds" or sore throats?	YES	NO
10. Do you have coughing, wheezing, shortness of breath or chest tightness?	YES	NO

FOODS

1. Do foods cause rashes or swelling?	YES	NO
2. Are bothered by nausea, "heartburn" or stomach pain?	YES	NO
3. Do you have nausea, vomiting or diarrhea?	YES	NO

SURVEY

Do any of the following cause eye, nasal, lung or sinus symptoms?

1. Cats	YES	NO
2. Dogs	YES	NO
3. Horses	YES	NO
4. Rabbits	YES	NO
5. Weather Changes	YES	NO
6. Tobacco Smoke	YES	NO
7. Car Fumes	YES	NO
8. Cleaning Agents	YES	NO
9. Perfumes	YES	NO
10. Cosmetics	YES	NO
11. Magazine/Newspaper Print	YES	NO
12. Grass	YES	NO
13. Dust	YES	NO

Name _____ DOB_____ Date_____

M.H.V. Strickland M.D.
ENVIRONMENTAL SURVEY

HOME SURVEY

1. Is your home: ☐ Wood ☐ Brick ☐ House ☐ Condo ☐ Apartment ☐ Trailer

2. How long have you lived there? _____ How old is it? _____

3. Do you have carpet in the living room? _____ Area rugs? _____House plants? _____

4. Is your home cooled/heated by gas/electric? _____
   ☐ Central Air ☐ Central Heat ☐ Attic Fan ☐ Fireplace ☐ Window Units ☐ Space heaters
   ☐ Other _____

5. Do you have a central humidifier? _____ or Electrostatic Air Filter? _____

6. Do you or anyone else smoke in your home? _____

7. What type of furniture do you have? ☐ Cloth ☐ Leather ☐ Other _____

8. If you have pets, do they live? ☐ Indoors ☐ Outdoors? What pets do you have? _____

PATIENT'S BEDROOM

1. What type of bed? ☐ Waterbed or ☐ Mattress/box springs? How old is it?

2. What type of pillow do you have? ☐ Feather ☐ Foam ☐ Cotton ☐ Dacron-polyester

3. Any stuffed animals in the room? _____ On the bed? _____

4. Carpeting in bedroom? _____ How old? _____ Is it in good shape? _____
   Musty odors? _____

WORK/SCHOOL SURVEY

1. What kind of work/school are you in? _____Do you travel? _____

2. Do you have allergy related problems while at work/school? _____

3. Is your work/school: ☐ Damp ☐ Dusty ☐ Smoky ☐ Other
   _____

4. Are there any: ☐ Fumes ☐ Gases ☐ Smoke ☐ Odors ☐ Powders ☐ Dust ☐ Varnishes
   ☐ Grain Dust ☐ Animal Dander ☐ Animal Feed ☐ Insecticides

5. Is the place cooled or heated by: ☐ Central Air ☐ Central Heat ☐ Attic Fans ☐ Window Units
   ☐ Fireplace ☐ Space Heaters ☐ Other _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: