Valley Allergy Asthma and Eczema Care Inc
684 N Medical Center Dr E Suite 105
Clovis, Ca 93611
Phone (559) 472-9716
Fax (559) 472-9872

Pediatric New Patient Intake Form

Patient Information

Child's Name: _____

Date of Birth: ___ / ___ / _____ Age: _____ Sex: ☐ M ☐ F ☐ Other

Parent/Guardian Name(s): _____

Preferred Contact: ☐ Phone ☐ Text ☐ Email

Primary Care Provider: _____ Phone: _____

Referring Provider: _____ Phone: _____

Reason for Visit (check all that apply)

☐ Allergic Rhinitis (sneezing, runny nose, congestion)

☐ Asthma / Breathing problems

☐ Food Allergy or Food Reactions

☐ Eczema / Atopic Dermatitis

☐ Hives / Swelling

☐ Recurrent Infections

☐ Other: _____

Main concern: _____

Birth & Early Childhood History

Birth: ☐ Full-term ☐ Premature (____ weeks)

Birth weight: _____ lbs _____ oz

NICU stay: ☐ No ☐ Yes (reason: _____)

Feeding history: ☐ Breastfed ☐ Formula-fed- Name- ☐ Both

Growth/Development: ☐ Normal ☐ Concerns (explain): _____

Allergic Rhinitis / Nasal & Eye Symptoms

☐ Sneezing ☐ Runny nose ☐ Congestion ☐ Post-nasal drip ☐ Itchy/watery eyes

Worst season: ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ Year-round

Triggers: ☐ Pollen ☐ Dust ☐ Animals ☐ Mold ☐ Weather ☐ Other

Prior treatments: _____

Response: ☐ Yes ☐ No

Asthma / Breathing Symptoms

☐ Cough ☐ Wheezing ☐ Chest tightness ☐ Shortness of breath

Frequency: ☐ Daily ☐ Weekly ☐ Rare

Nighttime symptoms: ☐ Never ☐ Sometimes ☐ Often

ER/hospital visits past year: _____

Steroid use past year: _____

Current inhalers/medications: _____

Food Allergy

Foods causing symptoms: _____

Reactions: ☐ Hives ☐ Swelling ☐ Cough/Wheezing ☐ Vomiting ☐ Diarrhea ☐ Anaphylaxis

Time from eating to reaction: ☐ Minutes ☐ Hours

ER visits: ☐ No ☐ Yes (details: _____)

Carry Epinephrine: ☐ No ☐ Yes

Eczema / Atopic Dermatitis

☐ Itchy rash ☐ Dry skin ☐ Thickened patches

Age of onset: _____

Locations: ☐ Face ☐ Arms ☐ Legs ☐ Hands ☐ Other

Triggers: ☐ Soaps ☐ Detergents ☐ Foods ☐ Weather ☐ Stress ☐ Other

Treatments tried: _____

Control: ☐ Good ☐ Fair ☐ Poor

Hives / Swelling (Urticaria / Angioedema)

☐ Hives (itchy welts) ☐ Swelling of lips/eyes/hands/feet

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rare

Duration: ☐ <24 hrs ☐ >24 hrs

Triggers: ☐ Foods ☐ Medications ☐ Infections ☐ Pressure/Heat/Cold ☐ Unknown

Treatments tried: _____

Response: ☐ Yes ☐ No

Past Medical History

☐ Asthma ☐ Allergic Rhinitis ☐ Eczema ☐ Food Allergy ☐ Hives/Swelling

☐ Recurrent Sinus Infections ☐ Pneumonia ☐ Ear Infections ☐ Immune Deficiency

☐ Autoimmune Disease ☐ Other: _____

Surgical History

☐ Tonsillectomy ☐ Adenoidectomy ☐ Ear tubes ☐ Sinus Surgery ☐ Other: _____

Medications

List prescriptions, inhalers, nasal sprays, OTC meds, supplements:

Allergies

☐ No Known Allergies

☐ Yes → List: _____

Immunization History

Vaccinations: ☐ Up to date ☐ Not up to date ☐ Unsure

Last Flu Shot: _____

COVID-19 Vaccine: ☐ Yes ☐ No

Family History

Asthma: ☐ Yes ☐ No (Who?)

Allergic Rhinitis: ☐ Yes ☐ No (Who?)

Eczema: ☐ Yes ☐ No (Who?)

Food Allergy: ☐ Yes ☐ No (Who?)

Hives/Swelling: ☐ Yes ☐ No (Who?)

Autoimmune Disease: ☐ Yes ☐ No (Who?)

Social & Environmental History:

School grade: _____

Lives with: ☐ Parents ☐ Siblings ☐ Other: _____

Pets: ☐ Cat ☐ Dog ☐ Bird ☐ Other

Are they allow to go into patient room: ☐ Yes ☐ No

Home: ☐ House ☐ Apartment

Place of living: ☐ City ☐ Suburb ☐ Country

Bedroom flooring: ☐ Carpet ☐ Hardwood ☐ Tile

HEPA/air filters: ☐ Yes ☐ No

Tobacco exposure: ☐ None ☐ Yes (who smokes? _____)

Mold/water damage: ☐ Yes ☐ No

Age of mattress: _____ Allergy protective covers on Mattress- ☐ Yes ☐ No

Cockroach/Rodent exposure- ☐ Yes ☐ No.

Consent & Acknowledgment

I consent to release of information for insurance and billing purposes.

I acknowledge receipt of HIPAA privacy policies.

Parent/Guardian Signature: _____ Date: ___ / ___ / _____

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Agreement and Authorization for Services

VI. Use of AI Transcription Technology and Audio Recordings

Under California law, it is illegal for a confidential communication to be recorded without the consent of all parties

involved. This includes conversations between doctors or medical professionals and their patients.

[Practice Name] may sometimes use artificial intelligence ("AI") transcription technology to help providers create notes about my care and update my medical record. The technology does this by analyzing audio of my visit and using it to write down conversations I have with my provider as they occur, similar to a physician's scribe. The provider must review and approve the record of the conversation to ensure it is correct before any AI created notes are added to my chart. The vendor used by Community Provider Plus is HIPAA-compliant to prevent unauthorized access to my protected health information. If I would like to allow my provider to use this feature, I must opt-in here. If I opt-in, I can verbally opt-out at any time during a specific visit to stop the use of the technology during that visit. At any time, I may completely revoke my consent to allow the use of the technology by notifying staff at my [Practice Name] clinic of my decision in writing. Choosing not to opt-in will have no effect on my ability to receive treatment.

The use of recording devices such as cell phones, audio recorders, or any other equipment used to capture or record images and/or sound by patients or other visitors without the consent of doctors or medical professionals is prohibited.

☐ By checking this box, **I provide my consent to the audio recording of my visits and the use of AI transcription technology** to help my provider create notes about my care and update my medical record. The recording and associated documentation may also be used for the further improvement of the AI technology.

☐ By checking this box, **I do not provide my consent to the audio recording of my visits or the use of AI technology** to help my provider create notes about my care and update my medical record.

I have read each of the foregoing, VI and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

Patient/Legal Representative/Guarantor Signature: _____ Date: _____

Patient Name: _____

If signed by someone other than patient, indicate relationship: _____

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Notice of Privacy Practice

I acknowledge that I have received a copy of VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC A Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC A may disclose and use my protected health information. I am encouraged to read the Notice of Privacy Practices in full.

Patient Name: Date: _____ Time: _____

Patient Signature/ Guardian: _____

If signed by the patient's representative/guardian, indicate:

1. Name of Signer: _____
2. Relationship to the patient: _____

☐ Decline to Sign Acknowledgement or Inability to Obtain Acknowledgement:

If acknowledgement is not signed, indicate reason not signed and efforts made to have acknowledgement signed:

☐ Patient/representative/guardian declines to sign
☐ Emergency condition prevented signature
☐ Other, Describe below:

_____
_____
_____
_____

Print Name/ Title:
_____

Date: _____ Time: _____ Signature: _____

Interpreter Signature if Applicable

I have accurately and completely read the foregoing document to

_____ (Patient or Legal Representative Name)

in _____ (Language), the patient's or legal representative's primary language.

(He/she) understood all of the terms and conditions and acknowledged (his/her) agreement thereto by signing the document in my presence.

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Agreement And Authorization for Service Consent

I. Consent for Diagnosis and Treatment

I acknowledge and understand that, in presenting myself for treatment and medical care to VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC, I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC medical staff and personnel. I understand that some of my medical care can and will be accomplished via remote Telehealth (also known as Telemedicine) visits, and I consent to their use where deemed medically appropriate by VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC medical staff. I am aware that medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination.

II. Retention of Information

I understand that VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC may record medical and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified non-VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure and program evaluation or other similar purpose. I will not be identified by name or other personally identifying information in any report of such research, audit or evaluation without my express written consent.

III. Release of Information

I hereby authorize VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC to release to my insurance companies, employer insurance groups, health plans, Medicare/Medicaid program, its insurance carriers or intermediaries any medical records or other information concerning this treatment to obtain reimbursement on my behalf for the treatment and services provided to me by VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC and the physicians associated with it. I may revoke my consent at any time for any reason by providing written notification to VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC. This authorization shall not conflict with any internal VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC policy regarding release of information which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a specific authorization under State or Federal Law.

IV. Teaching Program

I understand that appropriately supervised residents, interns, medical students, students of ancillary health care professions (e.g. nursing, xray, and rehabilitation therapy), post-graduate fellows, and other trainees may observe, examine, treat and participate in my care as part of educational programs.

V. Assignment of Benefits and Agreement to Cooperate in Collection Efforts

In consideration of the healthcare services provided to me by VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC, I hereby assign VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC, physicians, and other professionals associated with VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC all of my rights and claims for reimbursement under Medicare, Medicaid, or group accident or health insurance policy for which benefits may be available for payment of the services provided. In addition, I hereby agree to personally cooperate with, and

take all steps necessary, required or reasonably requested by any reimbursement source to effectuate, perfect, confirm or validate my assignment and authorization of VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC as my assignee and authorized representative, and to assist VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC with pursuing payment from any reimbursement source.

VI. Guarantee of Payment

I understand and agree that I am financially responsible for any and all charges related to any services rendered. While my claims may be paid by the above-mentioned coverage sources, I recognize that payment is not guaranteed and that I am ultimately responsible to pay VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC, physicians, and other professionals associated with VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees. I have read each of the foregoing, 1-VI and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

VI. Consent to Photograph

I hereby consent to be photographed while receiving treatment at VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC Practices.

I understand that the images form such photography may be used for my treatment or for hospital health care operations such as peer review or medical education, as the hospital or my treating provider(s) deem appropriate. The use of such images is subject only to the following limitations:

_____
_____
_____

The term “photograph” as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproduce images

I further understand that I must obtain consent from my treating provider(s) if I request that a procedure or treatment be photographed by VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC personnel. I also understand that the photography and photographs will be maintained in my electronic health record.

I have read each of the foregoing, 1-VII and full agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as me free and voluntary act.

Patient signature: _____ Date: _____

Guardian name if patient is under 18 years old: _____

Other (Record relationship to patient): _____

Witness: _____ Date: _____

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Financial and Billing Policies

Thank you for choosing VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC. We participate with a variety of insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. If you have any questions, call your health plan's member services department their number is listed in your benefit plan booklet or on your ID card.

Inform Us of Changes: If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and responsibility for the cost of the entire visit.

Bring Your Health Information: Bring your health insurance information to your visit. This includes identification, all insurance cards, and authorization/referral forms. We will ask you to sign forms such as a release of information, assignment of benefits and possibly additional forms depending on your visit.

Co-Payments, Deductibles and Co-Insurance: Co-pay's are due at time of your office visit. Under the terms of our contract with the various insurance plans we cannot waive any co-payments, deductibles or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience we accept cash, checks, debit, VISA, and MasterCard.

Patient Responsibility Balances: All patient responsible balances must be paid in full or a financial arrangement must be made at the time of your visit.

Deposits: For certain procedures, you may be required to pay a deposit or pay for the

service in full prior to treatment. **Prompt Payment:** We offer a prompt payment discount.

Please contact our Billing Department for details.

Prior Authorization: Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre-existing, or is not a covered service you will be asked to pay prior to the time of service.

HMO/Managed Care Plans: It is your responsibility to make sure a current referral has been obtained for your care with our providers. If a referral has not been obtained by your appointment you may need to reschedule your visit until you have a current referral. We realize this is an inconvenience, but without the referral VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC will not be reimbursed for the services provided.

Workers Compensation: Please bring your claim number, date of injury and employer/workers compensation information. Your claim needs to be open and valid for the condition that we are seeing you for.

Statements: You will not receive a statement until your primary insurance company has fulfilled its financial responsibility or a service is determined to be patient responsibility.

Who Can Discuss a Bill: Confidentiality is important. Our Patient Account Representatives may only speak with the patient or the person designated in writing by the patient to receive the bill(s) on behalf of the patient.

I have read, understand, and agree to the above Financial and Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC. I authorize VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC to release pertinent medical information to my insurance company when needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform VALLEY ALLERGY ASTHMA AND ECZEMA CARE INC of any changes regarding my personal billing information or my insurance billing information.

Patient/ Legal Representative/ Guarantor Signature:_____ Date: _____

Print name: _____ Date: _____

If signed by someone other than patient indicate relationship: _____

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Late Cancellation and No-Show Policy

To provide timely care to all our patients and to respect the time reserved specifically for you, Valley Allergy Asthma and Eczema Care has established the following appointment policy.

We kindly request that you notify our office at least 24 hours in advance if you need to cancel or reschedule your appointment.

Appointments cancelled with less than 24 hours' notice, or appointments where the patient does not arrive or arrives too late to be seen, will be subject to a $50 late cancellation/no-show fee.

This fee is not covered by insurance and will be the patient's responsibility. Repeated late cancellations or no-shows may result in limited scheduling availability or dismissal from the practice.

We understand that unexpected situations may arise, and exceptions may be considered at the discretion of the physician for emergencies or extenuating circumstances.

Thank you for your understanding and cooperation.

Sahana Vishwanath, MD, FACAAI
Valley Allergy Asthma and Eczema Care, Inc.

Patient Name: _____ Date: _____
Patient/ Legal Guarding Signature: _____
Relationship with patient (if other than patient signature): _____