

New Patient Digital Intake

Allergy, Asthma & Immunology Institute | Laura Ispas, MD | 571-399-5132

Review copy for Dr. Ispas and ModuleMD. Estimated 15–25 minutes; complex histories may take longer. Estimate requires patient testing. Show follow-up questions only when relevant. Allow Unknown or Not applicable. Save progress securely. Autofill existing verified portal demographics and repeat patient name automatically; patient must review all prefilled information. Never infer medical answers.

1. Patient and contacts

Legal name, preferred name, date of birth, address, phone, email, preferred language, interpreter and accessibility needs. Height and weight with units. Completed by and relationship; guardian name and legal authority if applicable.

Primary care clinician: name, practice, phone and fax if known. Referring clinician: name, practice and phone; reason for referral. Emergency contact: name, relationship, phone. Preferred pharmacy: name, address and phone.

Primary and secondary insurance: insurer, member ID, group number, policyholder name and date of birth. Responsible party name, relationship and billing contact if different. Upload insurance cards if supported.

2. Reason for visit

Select all: nasal/eye allergies; asthma, wheezing or cough; sinusitis or infections; immune concerns; food reactions; medication reactions; hives or swelling; eczema; insect sting; prior allergy shots; other. Main concern and goal: _____. Symptoms began: _____. Frequency and triggers: _____. Treatments tried and response: _____.

3. Medical and surgical history

Have you been diagnosed with any of the following? Select all: asthma; nasal allergies; sinus disease; eczema; hives; immune deficiency; pneumonia; heart disease or stroke; high blood pressure; diabetes; thyroid disease; reflux or swallowing problems; autoimmune disease; cancer; kidney or liver disease; sleep apnea; other; none; unknown. If selected, condition and approximate date: _____. Hospitalizations and reason: _____.

Any surgeries or procedures? Yes / No / Unknown. If yes: procedure, reason and approximate date, including sinus surgery, tonsils, ear tubes and implants: _____. Any anesthesia or surgical complications? Yes / No / Unknown. Details: _____.

4. Medicines and reactions

List every medicine, including prescription, over-the-counter, supplements, inhalers, nasal sprays, eye drops, creams, biologics and injections. Repeat row: name, strength, dose, frequency, reason and response. None / Upload list if available. Recent antibiotics or steroids: name, dates and response. Most recent antihistamine and last dose date/time: _____.

Any reaction to medications, latex, adhesive, contrast, antiseptics or implants? Yes / No / Unknown. For each: substance, symptoms, time to onset, date, treatment and related medicines tolerated afterward: _____.

5. Family, social and environmental history

Family history: asthma, allergies, eczema, severe reactions, recurrent infections or immune deficiency? Yes / No / Unknown. If yes, relative and condition: _____.

Tobacco: Never / Current / Former; if applicable type, amount, years and quit date. Vaping: Never / Current / Former. Secondhand exposure: Yes / No. Alcohol: None / Current / Former; type, amount and frequency.

Cannabis or other drugs: None / Current / Former / Prefer not to answer; details if relevant. Occupation or school; household members; exercise or activity limitations: _____.

Home or work exposure: pets; dust; mold or dampness; pests; smoke; chemicals; other; none; unknown. Describe relevant exposures: _____.

6. Review of symptoms

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In the past four weeks have you had any of the following? Select all that apply, or None / Unsure. For any selected item, briefly describe timing and severity.

General: fever, fatigue, weight change. Eyes: itching, redness, swelling, vision concerns. Ears/nose/throat: congestion, sneezing, drainage, sinus pain, ear pain, sore throat, trouble swallowing. Lungs: cough, wheezing, shortness of breath, chest tightness. Heart: chest pain, palpitations, leg swelling. Digestive: nausea, vomiting, abdominal pain, reflux, diarrhea, constipation. Skin: rash, itching, hives, eczema, swelling. Muscles/joints: pain, stiffness, swelling. Neurologic: headache, dizziness, weakness, numbness. Other: urinary problems, unusual bleeding or bruising, enlarged lymph nodes, mood or sleep concerns. Details: _____.

7. Allergy and asthma details

Nasal or eye allergies? Yes / No / Unknown. If yes: symptoms, season, triggers, prior testing, medications tried and benefit; prior allergy shots, duration and reactions: _____.

Asthma or breathing problems? Yes / No / Unknown. If yes: symptoms per week; nights awakened; reliever inhaler name and days used per week; exercise or sleep limits; triggers; prior lung tests; spacer use. Past 12 months: oral steroid courses, urgent visits, ER visits and hospitalizations. Ever ICU or breathing tube? Yes / No / Unknown. Details: _____.

Food reaction? Yes / No / Unknown. If yes: food, amount, symptoms, time to onset, treatment, date and foods tolerated since; epinephrine prescribed or used? _____.

Hives, swelling or eczema? Yes / No / Unknown. If yes: location, duration, frequency, triggers, treatment and response. Upload photographs if supported. Insect sting reaction? Yes / No / Unknown. If yes: insect, symptoms, timing and treatment: _____.

8. Infection and immune history

Frequent or severe infections? Yes / No / Unknown. If yes: number in past year of sinus, ear, bronchitis and pneumonia episodes; antibiotics and duration; hospitalizations or IV antibiotics; cultures, imaging and recovery. Lifetime pneumonia and dates: _____.

Prior immune testing, low immunoglobulins, vaccine response testing, immune treatments or family history of immune deficiency? Yes / No / Unknown. If yes, dates and details: _____.

9. Review and sign

Please review your answers. I confirm they are accurate to the best of my knowledge. Signature and date. If representative: printed name, relationship and authority.

Privacy acknowledgment: I received or was offered the Notice of Privacy Practices. This acknowledgment does not authorize release of records. Signature and date. Display the complete notice separately.

General care: I request evaluation and routine care. My clinician will explain procedures requiring separate consent. I may ask questions or decline recommended care. Signature and date.

Communication: phone / secure portal / text reminder / email reminder / mail. Voicemail: callback only / detailed message / no voicemail. Optional people involved in care and restrictions: _____.

AI documentation: Agree / Decline. The clinician reviews the note. I may decline or stop recording without losing access to care. Separate signature/date if required.

Benefits assignment: I authorize applicable insurance payments to AAIL and lawful claims-related disclosures as permitted by my plan. Signature and date.

Financial policy and card authorization: present the complete current terms below and obtain separate signatures after review. Payment card details must be entered through the approved secure processor. Other service-specific consents, records releases and Medicare ABN appear only when needed and completed by staff before signature.

Financial Policy and Card on File

Financial responsibility agreement Payment deadlines, interest, and collection policy Patient name Date of birth

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VERIFY YOUR BENEFITS: Before receiving services, you are responsible for contacting your insurer to verify that AAIL and the proposed services are covered, and to confirm referral / authorization requirements, exclusions, visit or testing limits, and remaining deductible, copayment, and coinsurance obligations. Specifically ask about skin testing, allergen extract preparation, allergy injections, and pulmonary function testing when planned. Any benefits information supplied by AAIL is an estimate, not a coverage guarantee. AAIL retains its own obligations under law and payer contracts. **PAYMENT AT SERVICE:** Applicable copayments and known or reasonably estimated deductible and coinsurance amounts are due at the time of service, without waiting for insurance to process the claim, except where law or your payer agreement prohibits advance collection or AAIL approves a written arrangement. Deductible estimates use available benefit information and applicable contracted rates. Advance payments are credited to your account and reconciled with the insurer determination; overpayments will be refunded or credited as permitted by law. Any remaining lawful patient balance is due within 30 days of the statement. Insurance denial or delay alone does not establish patient liability. Contractual adjustments and provider-liability amounts will not be transferred to you. **INTEREST:** Eligible unpaid patient principal will accrue simple interest at 5% per year beginning on day 61 after the initial statement is mailed or presented, unless law or payer rules prohibit interest or require a lower rate or later start. Interest is not compounded and is shown separately. No interest applies to insurer-only balances, contractual write-offs, or AAIL payment-processing errors. **COLLECTIONS - THREE STATEMENTS:** AAIL will issue three billing statements for unpaid patient balances. The third statement will serve as the final collection notice and allow at least 30 days to pay or arrange payment. After three statements, a valid unpaid balance will automatically be referred to an outside collection agency once both 90 days from the initial statement and the final 30-day notice period have passed. Referral will be held while an approved payment plan is current or a billing dispute is under review. Any extraordinary collection action will comply with applicable prohibitions, the 120-day period after the final invoice due date, and required advance notices. Agency interest must comply with its applicable limits. Medical debt will not be reported to consumer reporting agencies where prohibited. **COSTS:** Reasonable collection costs, court costs, and attorney fees actually incurred may be sought only if authorized by law and payer agreements and awarded by a court when required. No automatic percentage collection surcharge is imposed. **PAYMENT PLANS / QUESTIONS:** Contact 571-399-5132 before the due date to request an itemized bill, report an error, or request a written payment plan. An approved plan states amounts, due dates, and interest terms. No referral while the plan is current. Missed payments receive written notice and an opportunity to cure. Disputed amounts will be reviewed before referral; undisputed amounts remain due. These procedures do not limit legal rights. **MISSED VISITS:** Cancel or reschedule at least 24 calendar hours before the appointment. Otherwise, a \$100 new-patient or \$50 established-patient missed-visit fee may apply, except when prohibited by law or payer rules. These fees are not billed to insurance. Contact AAIL about emergencies or exceptional circumstances.

Patient / responsible party signature _____ Date _____

Printed name / relationship _____ Legal authority, if representative _____

Required card-on-file authorization AAIL payment policy | Please review and sign below. Patient name _____ Date of birth _____

AAIL requires a valid payment card on file unless an exception is required by law or approved by AAIL in writing. By signing below, I authorize AAIL to use a securely tokenized payment method for lawful patient balances after insurance adjudication, agreed copayments, and agreed missed-visit fees where permitted. This does not authorize charges for contractual adjustments or disputed amounts pending review. AAIL will give at least 10 calendar days notice of the amount, reason, scheduled charge date, and any eligible credit-card surcharge. I may contact AAIL before the charge date with billing questions or use another accepted payment method. A receipt will be provided. Where law and payer contracts permit, an eligible credit-card surcharge will not exceed 3% or the applicable cost of acceptance, whichever is lower. The exact rate and amount will be disclosed before payment. No surcharge applies to debit or prepaid cards, even when processed as credit. Check and accepted debit payments are available without this credit-card surcharge. Processor-approved credit-card rate (%) _____

Authorization charge limit per transaction (\$) _____

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I acknowledge the card-on-file requirement and authorize charges within the limits and advance-notice procedures stated above. Cardholder name Card brand / LAST FOUR digits only

Do not write the full card number, security code, or banking credentials on this form. Enter payment information through the secure processor. I may revoke future automatic charges by notifying AAI in writing; revocation does not cancel a valid debt or reverse an already processed payment. AAI may not increase this authorization limit without new permission. Patient / responsible party signature Date

Printed name / relationship Legal authority, if representative

AAI New Patient Intake

1 Patient and contacts

Complete what you can. Use Unknown when unsure. Continue on a separate list if needed.

Legal name / preferred name

Date of birth / height / weight (include units)

Address, city, state and ZIP

Phone / email / preferred language or interpreter

Completed by / relationship / legal authority

Primary care clinician / practice / phone

Referring clinician / practice / phone / reason

Emergency contact / relationship / phone

Preferred pharmacy name / address / phone

Insurance plan / member ID / group / policyholder

Secondary insurance / responsible party details

Main concerns, symptoms, onset, frequency, triggers and treatment response

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Medical conditions and hospitalizations / dates (or None / Unknown)

Surgery, procedures, dates and complications (or None / Unknown)

All medicines: name, strength, dose, frequency, reason and response

Recent antibiotics or steroids; antihistamine and date/time last taken

Medication, latex or other material reactions?

☐ Yes

☐ No

☐ Unknown

If yes: substance, symptoms, onset, treatment and tolerated medicines

Family history: condition and affected relative (or None / Unknown)

Occupation / school, household, activity and limitations

Tobacco and vaping: never / current / former; amount, years, quit date

Alcohol and drugs: type, amount, frequency or None / Prefer not to answer

Environmental exposures: pets, dust, mold, smoke, work or other

Review of symptoms: describe any selected symptoms from the review pages

Nasal or eye allergies?

☐ Yes

☐ No

☐ Unknown

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Symptoms, triggers, season, testing, medicines and prior shots

Asthma, wheezing, breathlessness or cough?

☐ Yes

☐ No

☐ Unknown

Days and nights with symptoms; reliever use, triggers, exercise limits

Steroid courses, ER visits, hospitalizations or ICU; lung tests

Complete what you can. Use Unknown when unsure. Continue on a separate list if needed.

Food reaction?

☐ Yes

☐ No

☐ Unknown

Food, timing, symptoms, treatment, epinephrine and foods tolerated

Hives, swelling or eczema?

☐ Yes

☐ No

☐ Unknown

Location, duration, triggers, treatment and response

Insect sting reaction?

☐ Yes

☐ No

☐ Unknown

Insect, timing, symptoms and treatment

Frequent or severe infections?

☐ Yes

☐ No

☐ Unknown

Number and type in past year, antibiotics, pneumonia, testing and hospital care

Prior immune tests, immune treatments or family immune deficiency?

☐ Yes

☐ No

☐ Unknown

Dates and details of immune testing, treatments or family history

Other information or concerns

Communication preferences and voicemail instructions

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People involved in care, relationship, phone and restrictions (optional)

Do you agree to AI-assisted documentation?

☐ Yes

☐ No

☐ Unknown

Accuracy acknowledgment - type name and date

Privacy notice acknowledgment - type name and date

Consent to routine care - type name and date

Assignment of benefits - type name and date

Financial policy acknowledgment - type name and date

Card-on-file authorization - type cardholder name and date

Card authorization: limit per charge / surcharge rate / card brand and last four only

Representative name, relationship and authority, if applicable

Use the secure processor for payment information. Do not enter full card number or security code.

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Authorization to Release Medical Information

Optional. Complete all applicable fields before signing.

Patient name and date of birth

Person or organization authorized to disclose information

Recipient name, organization, address, phone and secure delivery details

Specific records and dates of service to disclose

Purpose of disclosure

Expiration date OR event related to the purpose

I may revoke this authorization in writing to the AAI Privacy Officer, 19455 Deerfield Avenue, Suite 207, Lansdowne, VA 20176, except to the extent action has already been taken in reliance on it. AAI generally will not condition treatment, payment, enrollment, or eligibility on this authorization, except as permitted by law. Information disclosed may be redisclosed by the recipient and may no longer be protected by HIPAA; other confidentiality laws may still apply. Specially protected records may require additional consent or a separate authorization. This form does not by itself authorize psychotherapy notes or override 42 CFR Part 2 protections. Ask staff before including such records. I may receive a copy of this signed form.

Patient or representative signature (typed name) and date

Printed name, relationship and legal authority if representative