**Demographic Information**
**Please fill out all fields**

Patient Legal Name | Date of Birth | Age | Social Security Number

Email Address | Home Phone Number | Cell Phone Number

Street Address | City | State | Zip

Primary Care Physician | Phone Number

Preferred Language | **Marital Status:** Single Married Divorced Separated Widowed Civil Union

☐ I choose to receive statements by email only. Please sign the agreement included with this packet.

**Parent/Legal Guardian Information (IF APPLICIABLE)**

Patient Parent / Legal Guardian | Relationship to patient

Date of Birth | Social Security Number

Street Address | City | State | Zip

Emergency Contact (other than Parent / Legal Guardian) | Phone Number

Revised 11/23/2021

**Reason for Visit**_____

| Current Medications | Medication Allergies |
|---|---|
| | |
| | |
| | |
| | |

| Family History | Self | Father | Mother | Father's Parents | Mother's Parents | Siblings | Children |
|---|---|---|---|---|---|---|---|
| Heart Disease | | | | | | | |
| High Blood Pressure | | | | | | | |
| Stroke | | | | | | | |
| Cancer | | | | | | | |
| Glaucoma | | | | | | | |
| Diabetes | | | | | | | |
| Epilepsy/Convulsions | | | | | | | |
| Bleeding Disorder | | | | | | | |
| Kidney Disease | | | | | | | |
| Thyroid Disease | | | | | | | |
| Mental Illness (EX. Bipolar, Depression, Anxiety) | | | | | | | |
| Osteoporosis | | | | | | | |

**Authorization**: I consent to any medical diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulation in the code 42 of Federal Regulations, part 2, if any; psychological services records, if any; social service records, if any; including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any; and I authorize and request my insurance company to pay directly to Dr. Michel Alkhalil/Dr.Rahal the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by my insurance. I understand that if any employee, physician, or agent of the office of Dr. Michel Alkhalil sustains a per-cutaneous (through the skin) mucous membrane (through the mouth or eye), or open wound exposure to any blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AAIDS).

**I hereby certify that the contents of this and all forms are understood by me. Paragraphs or lines that I choose not to pertain to me, if any, were stricken before I signed.**

Signature_____

Date_____

## NOTICE OF PAYMENT

PATIENT NAME: _____

DATE OF BIRTH: _____

NAME OF LEGAL GUARDIAN: _____

The purpose of this "Notice of Payment" is to inform you that Testing to be performed will be submitted to your insurance company for payment.
By signing this notice, you understand that the patient above named will be held responsible for any amount not covered by patient's insurance company.
This is true for the date of service listed above, as well as any testing in the future.

SIGNATURE: _____

## CANCELLATION POLICY

Please be advised that in case of cancellation, we ask that you call our office no later than 24 hours prior to the procedure, otherwise there will be a:

$ 20 charge for no call no show office visits.

$ 100 charge for late cancellations.

I understand that the above instructions will be enforced.

SIGNATURE: _____

DATE:_____

Revised 11/23/2021

**Troy Sleep Center & AAIRS Allergy Payment Policy**

Thank you for choosing us as your provider. We are committed to providing you with quality health care. We have developed this payment policy to help avoid confusion regarding patient and insurance payment responsibilities. ***Please read and sign below. A copy will be kept on file with your medical records. Please feel free to ask any questions prior to signing the form.***

**1. Insurance -** We participate in many insurance plans, including Medicare. Although we try very hard to confirm your insurance coverage and whether our physicians are "in-network" with your insurance, it is your responsibility to have verified this information per your insurance policy contract. We try to do these things as a courtesy but will not be held responsible if an error is made. Although we are contracted with many insurance carriers, our services may not be covered by your insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services or will be "in-network" for our providers – you will be 100% responsible for all charges incurred, so please check with your insurance prior to your visit. Please confirm what your deductible is and if it has been met so you will be able to make the best financial decision regarding your visit to our practice. We will be happy to provide the billing information needed to verify if you have coverage for our services.

**2. Payment -** We expect all co-pays to be collected at the time of service. If the deductible amount is known, we may ask for that payment at the time of service as well. This arrangement is part of your contract with your insurance company. Failure to collect deductibles and co-pays from patients can be considered fraud. **We accept cash, check, Care Credit, and credit card payments**. You may be asked to pay a percentage of a balance larger than $100 prior to receiving additional services from our physicians. Please contact our office if you need to set up a payment plan.

**3. Claim Submission -** We will file all insurance claims to the insurance we have on file for your account and assist you in any reasonable way to help get claims paid. **You are responsible for any unpaid balances from your plan after billing**. It is your responsibility to respond to any direct requests from your insurance company to help resolve a claim issue. Remember, your insurance benefit is a contract between you and your insurance company, and we are not party to that contract.

**4. Non-Payment -** If your account is over 90 days past due and you have not made payment arrangements, your account may be sent to collections. You and your immediate family members may be discharged from our practice due to non-payment. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care and our physicians will only be able to treat you on an emergency basis during that time. We reserve the right to require payment prior to scheduling an appointment when an account has an outstanding balance and payments are not being received every 30 days.

**5. Missed Appointments** – Our practice is to charge $20.00 for missed appointments not cancelled within 24 hours of the appointment. The same fee is charged if you are a no-show for your appointment. These charges will be your responsibility and billed directly to you.

**6. Accounting Principles -** Payments are applied to the oldest outstanding balances first, except for insurance payments which are applied to the corresponding dates of service.

**7. Returned Checks -** A fee of $30.00 will be charged for returned/NSF checks. You will be asked to pay this fee in addition to the balance owed and may be asked to pay cash or certified funds prior to receiving additional services from our practice. Bad checks are subject to collections if payment is not made.

**I have read and understand the payment policy and agree to abide by the payment policies of Troy Sleep Center and AAIRS Diagnostics, PC.**

_____ _____

**Signature of the patient or responsible party (Guarantor)** **Date**

_____

**Please print the name of the patient**

# Allergy Skin Testing Instructions

## PLEASE DO NOT TAKE ANTIHISTAMINES FOR AT LEAST 7 DAYS PRIOR TO ALLERGY SKIN TESTING.

If you are scheduled for skin testing to medications, environmental, food, local anesthetics, or insect venoms, the following guidelines apply. No prescription or over the counter antihistamines should be used 7 days prior to the scheduled skin testing appointment. These include cold tablets, sinus tablets, hay fever medications or oral medications for itchy skin. Some names of commonly used antihistamines include **Actifed**, **Allegra**, **Benadryl**, **Chlorpheniramine**, **Chlortrimeton**, **Tylenol allergy sinus**, **Claritin**, **Dimetapp**, and **Zyrtec**. You must also avoid nasal antihistamine spray such as **Astelin,Patanase**

If you have any questions regarding whether you are using an antihistamine, please contact our office.

## You may take the following medications:

1) You may continue your intranasal steroid sprays such as, Beconase, Flonase, Nasacort, Nasarel, Nasonex, and Rhinocort.

2) All asthma inhalers, leukotriene modifiers (Singulair) do not interfere with skin testing and should be continued as prescribed.

If for any reason you need to change your skin test appointment, please give us at least 48-hour notice, due to the length of time scheduled for skin testing. A last-minute change results in the loss of valuable time that another patient might have utilized

# SKIN TESTING COVERAGE AND CONSENT

**REMINDER ALL PATIENTS ARE RESPONSIBLE FOR FINDING OUT IF ALLERGY TESTING IS COVERED UNDER THEIR INSURNACE PLAN, AS THIS IS PATIENT SPECIFIC:**

- **Codes: 95004-Skin test**
- **Estimated units charged: 50-150 depending on amount of tests**

☐ **I Would like to proceed with allergy skin testing irregardless of my insurance coverage.**

☐ **I will contact my insurance prior to skin testing to verify my coverage**

Patients Name: _____

Signature_____ Date___

Michel Alkhalil, M.D.
Pediatric & Adult Sleep Medicine
Pediatric & Adult Allergy, Asthma & Immunology

Peggy N. Rahal, M.D., F.C.C.P.
Pediatric & Adult Sleep Medicine
Pulmonary Disease & Critical Care Medicine

Board Certified Specialists in Sleep Medicine, Pulmonary Disease & Critical Care Medicine

1/01/2018

**HIPAA Compliance Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed: _____

This consent was signed by: _____
(PRINT NAME PLEASE)
Signature: _____ Date: _____
Witness: _____ Date: _____

**Troy Sleep Center& AAIRS Diagnostics**
**Phone**: 248-689 1000 **Fax**: 248-689 5711

**TROY SLEEP CENTER & AAIRS ALLERGY, PC**

## Request for Electronic Access and Authorization for Email Communication

Name: _____Email: _____

**Please Print Legibly**

**I understand I will only receive statements by email – no paper statements will be sent.**

I authorize Troy Sleep Center to contact me using the email address provided above (including my name, information regarding my account balance and instructions for accessing the patient portal).

I understand that:

- The information is being sent will be used to communicate with me and will allow me to set up an account to access the patient portal.
- My name, provider number and account balance could be viewed by anyone who has access to the email address provided and that if my email is unsecured, the information could potentially be intercepted. (However, information in the patient portal will only be accessible to someone who has the answer to certain questions that are expected to be known only to me.)
- This authorization will be in force and effect until I terminate my relationship with the practice or revoke the authorization by making a request in writing to: 1500 W. Big Beaver Rd., Ste 107, Troy, MI 48084 - Attn: Billing

I further understand that:

- A revocation is effective only to the extent that the practice has not already relied upon it.
- Information used or disclosed pursuant to this authorization (name, email, practice name, account balance) may be used by a recipient of the email communication and then will be no longer protected by federal or state law.
- I can refuse to sign this authorization and the practice will not condition my treatment on whether I sign.
- I have the right to inspect or copy my protected health information as permitted by federal and state laws.

Signature: _____Date: _____

Revised. 11/23/2021