



Board Certified Specialists in Allergy, Asthma & Immunology

Appointment Date: _____
Appointment Time: _____
Location: _____

Dear

Welcome to our practice. We are honored that you have chosen us as your healthcare provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. Here is some information that will help make your first visit a little easier.

IF YOU DO NOT COMPLETE THESE FORMS ON THE PATIENT PORTAL YOU WILL NEED TO ARRIVE IN OUR OFFICE AT LEAST TWENTY (20) MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME.

Enclosed with this letter are the following forms: (unless you are completing these forms on the patient portal)

1. New patient information form
2. Directions to our locations
3. **Records Release Form-** If you have seen another physician regarding the reason for your visit, please use this form to request that your records be sent to us from your primary care/pediatrician and/or specialists (pulmonologist/ENT/dermatologist) prior to your visit or sign the form (do not list a physician office) and present it to the receptionist upon arrival. If you need multiple forms for multiple doctors, you may copy this form or print it from our website at www.AllergySpecialistsofKnoxville.com
4. **Notice of Privacy Practices forms** (present a signed "Acknowledgment of Receipt of Privacy Practices" to the receptionist.)
5. **Antihistamine Medications to AVOID for testing and Medications that DO NOT interfere with testing**

Patients should discontinue ALL antihistamines at least seven days before coming for testing.

(If you are on beta-blockers, DO NOT discontinue, we ask you to contact us regarding this medication)

Bring all current medications or list of all of current medications to your appointment.

Please bring your insurance card(s), a photo ID and any necessary referrals.

Please refrain from wearing any perfume or cologne to the office. These chemicals are very irritating to those who have allergies. Thank you for your cooperation & consideration!

We encourage you to call your insurance plan and verify your benefits and eligibility before your appointment.

We want your visit to be a pleasant one! Plan to be in our office for 2-3 hours if you are undergoing allergy testing. All treatment is individualized, and therefore, we can only provide you with a time estimate. You may want to bring a book, electronic device or if a child some toys.

If this appointment is not for a child we suggest that children not accompany you. Allergy testing requires the patient to be perfectly still and we have found that patients with children are unable to do this. Wearing clothes that allow easy access to the back, upper arms and thighs is advisable. We also advise patients to bring along a sweater or zip-up fleece.

Because of the length of time we have set aside for you, we ask that you let us know at least 24 hours in advance if you are unable to keep this appointment.

We look forward to meeting you. Please do not hesitate to call us at 865-588-2753 if you have any questions prior to the visit. You may also visit our website at www.AllergySpecialistsofKnoxville.com.

Sangeetha M. Kodoth, M.D.

1346 DOWELL SPRINGS BOULEVARD • KNOXVILLE, TN 37909
PHONE: 865-588-2753 • FAX: 865-588-7418
www.AllergySpecialistsofKnoxville.com

Antihistamine Medications To Avoid: A Partial List

Antihistamine medications can affect allergy skin testing. Please check the labels of all medications you are using (including nasal sprays and eye drops) to determine whether your medications contain any ingredient listed below. For questions, contact your pharmacist or our office.

- **Stop these oral antihistamines 7 days before your appointment:**

- Claritin®, Claritin D®, Alavert® (loratadine), Clarinex®, Clarinex D® (desloratadine)
- Allegra®, Allegra D® (fexofenadine)
- Zyrtec®, Zyrtec D® (cetirizine), Xyzal® (levocetirizine)
- Actifed®, Dimetapp® (brompheniramine)
- Atarax®, Vistaril® (hydroxyzine)
- Benadryl® (diphenhydramine), Poly-Hist DM, Poly-Hist Forte, Poly-Hist PD, Lortuss DM
- Chlortrimeton®, AHist®, LoDrane 24®, LoDrane 24D®, (chlorpheniramine), Ala-Hist IR & PE
- Phenergan® (promethazine)
- Tavist®, Antihist® (clemastine)
- Periactin® (cyproheptadine)
- Actifed®, Aller-Chlor®, Bromfed®, Drixoral®, Dura-tab®, Novafed-A®, Ornade®, Poly-Histine- D®, Trinalin®, Extendryl Jr.®, Vasobid®, Vasotan®, Tussionex Cough Syrup® (Combination medicines)
- Over-the-counter cold remedies (Nyquil®, doxylamine, pyrilamine, pheniramine)
- Motion sickness and dizziness medications (Antivert®, Bonine®, Dramamine®, meclizine, dimenhydrinate)
- Heartburn medications (Zantac®, ranitidine, Tagamet®, cimetidine, Pepcid®, famotidine)

- **The following antihistamine nasal sprays should be avoided for 7 days prior to testing:**

- Astelin®, Astepro®, Patanase®

- **The following antihistamine eye drops should be avoided for 7 days prior to testing:**

- Patanol®, Pataday®, Zaditor®, Optivar®, Elestat®, Alaway®, Visine Allergy Eye Drops®



SANGEETHA M. KODOTH, M.D.
American Board of Allergy & Immunology
American Board of Pediatrics

I, _____ (parent) and _____ (parent)
authorize the following adult(s) to bring my child, _____ for
his/her allergy shots and/or medical visits (**please circle one or both of these options**).

These individuals have the right to authorize medical treatment under the direction of the doctor on
call if such treatment is needed.

Adults who may bring child for shot or visit: _____

Parent Signature: _____

Relationship to Patient: _____

If minor's first visit is without a custodial parent this form should be notarized.



1346 Dowell Springs Blvd, Knoxville, TN 37909

Phone: 865-588-2753

Office Fax: 865-588-7418 Fax Medical Records to: 865-321-8406

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ and its physicians, employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

I hereby authorize the release of medical records to: **Allergy Specialists of Knoxville**
1346 Dowell Springs Blvd, Knoxville, TN 37909

Fax for Medical Records : 865-321-8406

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records (past, present and future)

_____ Health care information relating to the following treatment, condition, or dates of treatment: From: _____ To: _____

_____ Specific records to be released (e.g. Labs, imaging reports, other):

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____ Substance abuse _____ Psychological or psychiatric treatment _____ HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except that revocation is not effective to the extent the practice has relied on the use or disclosure of the health information. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition my treatment on the signing of this authorization.

Signature of Patient or Authorized Representative

Date Signed

Relationship to Patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out Treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceeding; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Protected Health Information (PHI) / HIPAA

Due to recent implemented Federal Regulations the following public notice by Allergy Specialists of Knoxville is effective as of November 1, 2011.

Allergy Specialists of Knoxville is required to:

1. Maintain the privacy of your health information.
2. Provide you with this notice as to what our legal duties and privacy practices are with respect to information we collect and maintain about you.
3. Abide by the terms of this practice.
4. Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
5. We will not use or disclose your health information without your authorization, except as described in this notice.
6. We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUMSTANCES:

1. **Disclose Required By Law:** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety:** Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice might routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions.

All requests for medical records should be hand written and should contain:

Full Name

Date of Birth

Mailing Address

Phone Number

Written Signature

An additional fee might be asked for generating a copy or mailing all medical records as per the rules practiced by the clinic.

At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

Patient Rights

1. **Confidential Communications:** You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions:** You have the right to request restriction on our use of disclosure of you PHI for treatment, payment, or health care operations. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Inspection and Copies:** You have the right to request and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances. However, you may request a review of our denial.
4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for this practice. Your request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Rights to a paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions regarding this notice or would like to exercise any of your rights under this notice, you may contact:

Allergy Specialists of Knoxville
1346 Dowell Springs Blvd.
Knoxville, TN 37909
Phone 865-588-2753

Retain this copy for your files

Allergy Specialists of Knoxville

****Complete and return to Receptionist****

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Allergy Specialists of Knoxville and understand that if I have questions regarding this Notice I may contact the office in writing at 1346 Dowell Springs Blvd. Knoxville, TN 37909 or by phone at 865-588-2753.

Indicated below are names of any Person(s) to whom I would like Allergy Specialists of Knoxville to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate "All" if appropriate).

Name	Relation to Patient	Allowed Disclosure

Name	Relation to Patient	Allowed Disclosure

Name	Relation to Patient	Allowed Disclosure

Patient Name: _____

Patient or Parent/Guardian Signature: _____ Date: _____

Medications That Do Not Interfere with Allergy Skin Testing

The following medications listed below **DO NOT** interfere with skin testing and may be continued up until your allergy appointment. (This list is not all inclusive, but it does include some of the more common medications that our new patients may be taking.)

Decongestants: Sudafed ®, pseudoephedrine, phenylpropanolamine

Leukotriene Inhibitors: Singulair ®, Accolate ®, Zflo ®

Corticosteroids: prednisone, prednisolone, methylprednisolone, Medrol ®, Orapred ®

Corticosteroid Nose Sprays: Nasonex®, Nasacort AQ®, Omnaris®, fluticasone, Flonase®, Veramyst®, Rhinocort Aqua ®

Expectorants: Mucinex ®, guaifenesin

Cough suppressants: Delsym ®, dextromethorphan

Asthma inhalers and all nebulized asthma medications: all are OK – please do not stop them for testing

Reflux medications: Protonix ®, Prevacid ®, Aciphex ®, Nexium ® , Prilosec ®, omeprazole

Other medications that do not affect skin testing include:

Antibiotics	Anticonvulsant medications
Arthritis medications	Birth control pills and female hormones
Cardiac medications	Cholesterol medications
Diabetes medications	Eye drops used for glaucoma, steroid eye drops
Thyroid medications	

Most medications for hypertension (high blood pressure) including: Norvasc ®, amlodipine, Cardizem ®, diltiazem, felodipine, Cardene ®, nicardipine, Procardia ®, nifedipine, nisoldipine, Calan ®, Veralan ®, verapamil, Lotensin ®, benazepril, Atacand®, candesartan, Capoten ®, captopril, Vasotec®, enalapril, Monopril ®, fosinopril, Avapro ®, irbesartan, Cozaar ®, losartan, Benicar ®, olmesartan, Accupril ®, quinapril, Micardis ®, telmisartan, Diovan ®, valsartan. **If you are taking a BETA BLOCKER, please tell our receptionist when scheduling your appointment.**

Most medications for insomnia and depression including: Ambien, zolpedem, Lunesta, Xanax, alprazolam, Ativan, lorazepam, Valium, diazepam, Prozac, fluoxetine, Effexor, venlafaxine, Zoloft, sertraline, Celexa, citalopram, Lexapro, escitalopram, Wellbutrin, bupropion, Paxil, paroxetine, Cymbalta, duloxetine.

PRIVACY INFORMATION: You will receive a copy of our Notice of Privacy for Personal Health Information Policy. Extra copies can be found in our lobby, and can also be printed from our web site. The following statements direct us regarding how we handle your personal information. I authorize Allergy Specialists of Knoxville, PLLC:

1. To notify me by: (mark all that apply) () mail () phone () email of appointment reminders and/or to contact me regarding medical information (including test results). A message may be left on my home answering machine. YES NO

2. If unable to reach me at home, the practice of Allergy Specialists of Knoxville, PLLC, may leave a message where I work, asking me to return their call YES NO

3. Please list the names of family members, if any, with whom we may share your medical information: _____

I acknowledge I have received a copy of Allergy Specialists of Knoxville, PLLC's Notice of Privacy for Personal Health Information.

Signature of Patient or Person Authorized to Consent for Patient Date: _____

Please print patient's name: _____ Patient's Date of Birth: _____

Please print name of person signing for patient (if applicable): _____

Relationship to patient: _____

INSURANCE INFORMATION (Please allow us to make copies of your insurance cards.)

Primary Insurance: _____ Effective Date of Coverage: _____

Secondary Insurance: _____ Effective Date of Coverage: _____

INSURED'S INFORMATION (who is the primary holder of the insurance?)

Insured's full name: _____ Relationship to the patient: _____

Insured's Birth Date: _____ Home phone: _____ Cell: _____

Insured's Employer: _____ Insured work phone: _____

Employer Address: _____
Street City State Zip

Insured's Social Security Number: _____ Drivers License Number: _____ State: _____

BILLING INFORMATION IF PATIENT IS A CHILD (under 18 yrs): (person attending the appointment with the child)

Responsible Party Name: _____

Relationship to Patient: _____ Home Phone: _____ Cell: _____

Home Address: _____
Street City State Zip

Employer: _____ Work Phone: _____

Employer Address: _____

EMERGENCY INFORMATION: In an emergency, notify: _____

Relationship to patient: _____ Home phone: _____ Cell: _____ Work: _____

Please list any doctor you would want to receive a copy of your evaluation. (Referring physicians will automatically receive a copy, unless you tell us otherwise): _____



Sangeetha M. Kodoth, MD
Board Certified Specialist
in Allergy, Asthma & Immunology

OFFICE DIRECTIONS

IF YOU ARE LOST ON THE WAY TO ANY OF OUR OFFICES, PLEASE CALL THE MAIN OFFICE NUMBER FOR HELP

865-588-2753

Main Office: 1346 Dowell Springs Blvd, Knoxville, TN 37909 (Bearden/Middlebrook Area)

From Interstate-40 Westbound:

- Take exit 383 for Papermill Dr. It is easier if you get into the left lane of the exit ramp.
- Once you are on the exit ramp, it will split into two parts- Papermill and Weisgarber.
- Bear to your left, following the signs for Weisgarber Rd.
- Take the exit ramp for Weisgarber Rd. At the bottom of the ramp (at the light) turn right onto Weisgarber.
- Turn left at the third traffic light onto Middlebrook Pike.
- At the second traffic light turn right onto Dowell Springs Blvd.
- Take the Second right onto Lonas Springs Rd and then an immediate right into our parking lot and our entrance will be directly in front of you.

From Interstate-40 Eastbound:

- Take the Papermill Exit.
- Turn right at the stop light at the bottom of the exit ramp onto Papermill Dr.
- Turn right at the next stop light onto Weisgarber Rd.
- Turn left at the fourth traffic light onto Middlebrook Pike.
- At the second traffic light turn right onto Dowell Springs Blvd.
- Take the Second right onto Lonas Springs Rd and then an immediate right into our parking lot and our entrance will be directly in front of you.

Jefferson City Office: Jefferson Medical Commons, 120 Hospital Drive, Suite G50, Jefferson City, TN 37760

From Interstate-81: (Greenville)

- Take I-81 South
- Take exit 1B to merge onto I 40 W toward Knoxville
- Take exit 417 toward Jefferson City
- Continue on TN 92 N to 120 Hospital Drive

Jefferson Medical Commons is located to the right of the hospital. You can use the entrance in the front and take the elevator to the ground floor G50 or drive around to the back of the hospital and enter through the back door. Suite G50 is located 4th door on the left.

From Interstate-40: (Dandridge)

- Take Hwy 92 N to W Old Andrew Johnson Hwy
- Turn left onto Hospital Drive

Jefferson Medical Commons is located to the right of the hospital. You can use the entrance in the front and take the elevator to the ground floor G50 or drive around to the back of the hospital and enter through the back door. Suite G50 is located 4th door on the left.

From Interstate-40: (Knoxville)

- From I-40 E and take Exit 394 for US 11E/US-70 toward US-25W
- Use the left 2 lanes to turn left onto US 11E- keep left to continue to US 11 E
- Continue on Old Andrew Johnson Hwy to Jefferson Medical Commons, 120 Hospital Drive.

Jefferson Medical Commons is located to the right of the hospital. You can use the entrance in the front and take the elevator to the ground floor G50 or drive around to the back of the hospital and enter through the back door. Suite G50 is located 4th door on the left.