HIGHLANDS
Allergy and
Asthma Center, P.C.

NEIL D. WALLEN, M.D.

Allergy ▣ Asthma ▣ Immunology

933 Hwy. 126 ▣ Bristol, TN 37620 ▣ (423) 844-7000

Dear New Patient,

Thank you for choosing Highlands Allergy and Asthma Center. Your initial evaluation will include a thorough evaluation of your allergy and/or asthma history and current symptoms. In addition, time has been set aside for any necessary testing and a summary conference, during which Dr. Wallen will explain your test results and his recommendations for treatment. Your visit will take 1-1/2 to 2-1/2 hours.

In preparation for allergy testing, **you will need to discontinue antihistamine-containing medications 3 days (72 hours) before your appointment.** This includes both prescription and over-the-counter antihistamines. Most cold and allergy products contain antihistamines. Other products which contain antihistamines include: 1. Medications for motion sickness, including Dramamine and Antivert; 2. Over-the-counter medications for sleep such as Tylenol PM and Sominex; 3. Medications for nausea such as Phenergan; 4. Medications for reducing stomach acid, including Pepcid, Tagamet, Axid and Zantac (Prilosec and Prevacid **do not contain** antihistamine.); 5. Muscle relaxants such as Flexeril; and 6. Atarax, Vistaril and Hydroxyzine.

Tricyclic antidepressants, including Amitriptyline, Doxepin and Nortriptyline, also contain antihistamine and should be stopped 7 days before your appointment, but you should speak with your physician before discontinuing these medications.

If you are unsure whether it is safe to discontinue a medication, please contact your doctor before you stop taking it. If you are unsure about whether one of your medications contains antihistamine, or if you are unable to discontinue your antihistamines, contact our office. Prescription allergy nasal steroid sprays and asthma medications do not contain antihistamine. (Astelin, Astepro, Dymista and Patanase are the only nasal sprays that contain antihistamine and need to be discontinued **7 days prior to your appointment.**) **You do not need to discontinue your asthma inhalers.**

Out of courtesy to our staff and other patients, we ask that you give us 24-hour advance notice if you cannot keep your appointment. That will enable us to assign your 2-hour appointment slot to someone else. Patients who do not give us a 24-hour notice of cancellation will be asked to pay a $75 rescheduling fee if they want to schedule another appointment. We thank you for your understanding and cooperation regarding this policy.

We are confident that at Highlands Allergy and Asthma Center you will receive the most accurate and thorough evaluation available, and you will be offered the most up-to-date and effective treatment for your symptoms. We look forward to caring for you.

Sincerely yours,

Neil D. Wallen, M.D. and staff

NEIL D. WALLEN, MD
HIGHLANDS ALLERGY & ASTHMA CENTER – HMG
933 HWY 126
BRISTOL, TN 37620

(423) 844-7000

ON YOUR SCHEDULED APPOINTMENT DAY PLEASE BRING THE FOLLOWING:

*(1) ALL FORMS COMPLETED IN **BLACK INK ONLY***
(2) INSURANCE CARD(S)
(3) PHOTO IDENTIFICATION
*(4) **LIST OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING WITH THE STRENGTH AND HOW THE MEDICATION IS TAKEN***

PATIENT RESPONSIBILITY

WE ASK THAT YOU CONTACT YOUR INSURANCE COMPANY TO VERIFY COVERAGE FOR ALL ALLERGY TESTING.

YOU WILL BE RESPONSIBLE FOR YOUR COPAY, COINSURANCE & ANY DEDUCTIBLE NOT MET AT YOUR APPOINTMENT TIME.

THANK YOU

HMG
HOLSTON MEDICAL GROUP

Welcome to our office

Where did you hear about us?
❒ Yellow Pages (YP) ❒ Newspaper (NP) ❒ Website (WS)
❒ Friend or Family (FF) ❒ Physician Referral (PR)
❒ Other (OT) _____

OFFICE USE ONLY
Physician: _____
Approved by: _____
Date: _____

NEW PATIENT INFORMATION (Complete if different from billing party)

Name _____
First Middle Last

Address _____

City _____ State _____ Country _____ Zip _____ Phone # (____) _____

Birthdate _____ Sex M or F Race _____ Marital Status S M W D

Social Security # _____ Employer _____

Address of Employer _____ Work Phone # _____

May we contact you at work? Y N By E-Mail Y N E-Mail Address _____

Emergency Contact Name _____ Emerg. Phone # (____) _____

Relationship to billing party _____

Guarantor/Responsible Party

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____ Phone # _____

Birthdate _____ Sex M or F Marital Status S M W D

Social Security # _____ Driver's License # _____

Place of employment _____ Work Phone # _____

OTHER INFORMATION

Name and address of nearest relative not living with you _____

Address _____ City _____ State _____ Zip _____ Phone # _____

If you are currently under another physician's care, please list:

Name _____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to us? _____

INSURANCE

1. Primary Insurance Company Name _____

Group # _____ Policy Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

2. Secondary/Supplemental Insurance Name _____

Group # _____ Policy/Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.
By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:
I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date _____ Signature _____

Highlands Allergy and Asthma Center

EMR #: _____

PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DATE OF VISIT: _____

Full name of physician (if any) that referred you _____

Full name and location of other physicians who need a copy of your report _____

_____

_____

What is your age? _____ What is your occupation? _____

PART I: WHY ARE YOU HERE?

All three questions MUST BE ANSWERED. If none, write "None."

1. What are the MAIN SYMPTOMS YOU have been experiencing that you are here to be evaluated for? (Please, be specific, and **do not write "Allergies."**) _____

_____

2. Are you experiencing any OTHER SYMPTOMS or do you have OTHER CONCERNS you would like to discuss? 1. _____

2. _____

3. _____

3. Did your PHYSICIAN refer you for specific questions or concerns he/she has? _____

_____

PART II: OTHER SYMPTOMS YOU ARE EXPERIENCING

EYE **YES NO** _____

EAR **YES NO** _____

NASAL **YES NO** _____

FREQUENT THROAT-CLEARING **YES NO** _____

MUCUS IN THROAT **YES NO** _____

FREQUENT or SEVERE COUGH **YES NO** _____

FEVERS **YES NO** _____ How high? _____

CHEST PAIN **YES NO** _____ Is it **new** or **recently increased**? **YES NO**

WORSENING SHORTNESS OF BREATH **YES NO** _____

HEARTBURN **YES NO** _____

ACID REFLUX (for children, "sour burps" or "throw-up burps") **YES NO** _____

Highlands Allergy and Asthma Center EMR #: _____

PATIENT NAME: _____ DATE OF VISIT: _____

PART II: OTHER SYMPTOMS YOU ARE EXPERIENCING (continued)

Please circle any other symptoms you are experiencing that you think are significant, and explain.

DIARRHEA **YES NO** _____ Is it new or worse? _____

VOMITING **YES NO** _____

DIFFICULTY URINATING **YES NO** _____

FREQUENT URINATION **YES NO** _____

FREQUENT or SEVERE HEADACHES **YES NO** _____

RECENT WEIGHT LOSS OR GAIN **YES NO** _____

TOOTHACHE / DENTAL INFECTION **YES NO** _____

HIVES **YES NO** _____

ITCHY RASH **YES NO** _____

SHORTNESS OF BREATH OR TIGHT CHEST WITH EXERCISE (especially running), more than others of the same age (If patient is a child, please ask him/her now.) **YES NO**

PART III: ALLERGIES or INTOLERANCES TO MEDICATIONS

Include all oral meds, drops, sprays, inhalers and over-the-counter meds you cannot take

If none, write "None."

Name of drug	Symptoms you experienced	Approximate date of reactions

Highlands Allergy and Asthma Center EMR #: _____

PATIENT NAME: _____ DATE OF VISIT: _____

PART IV: YOUR CURRENT MEDICATIONS

Include any sprays, drops, inhalers, EpiPens and over-the-counter meds you carry or use once in a while.

If none, write "None." If you have a separate list write "List attached."

Name of drug	Dose (mg, # of sprays)	Times per day	Approximate start date

If you need more space, please ask for a separate sheet of paper.

PART V: OTHER MEDICATIONS YOU HAVE TRIED FOR THESE PROBLEMS

Has anyone prescribed ORAL OR INJECTABLE **STEROIDS (prednisone, cortisone shots, Orapred,** etc.) for these problems? *Do not include spray or inhaled steroids here.* YES NO

Did the symptoms improve while you were taking the steroids (cortisone)?

YES, THEY IMPROVED A LOT THEY IMPROVED SOME NO IMPROVEMENT

EMR #: _____

Highlands Allergy and Asthma Center

PATIENT NAME: _____ DATE OF VISIT: _____

PART V: OTHER MEDICATIONS YOU HAVE TRIED FOR THESE PROBLEMS (cont'd)

Has anyone prescribed ANTIBIOTICS for these problems? YES NO

Were any of them effective, even if just temporarily?

YES, HIGHLY EFFECTIVE THEY HELPED NO, NOT EFFECTIVE

Names of antibiotics that **were effective** (if you can recall them): _____

_____

Names of antibiotics that **were not effective**: _____

_____

Please circle all other oral meds, sprays, drops, inhalers you have tried for these problems in the past. If none, circle "I have tried no other medications below."

Oral meds

CLARITIN / LORATIDINE	CLARITIN D	BENADRYL
ZYRTEC /CETIRIZINE	XYZAL D	CHLORPHENIRAMINE
ALLEGRA/FEXOFENADINE	SINGULAIR	CHLORTRIMETON
CLARINEX	ACCOLATE	DOXEPIN/SINEQUAN
XYZAL	HYDROXYZINE(Atarax, Vistaril)	GUAIFENESIN / (D)
ZYRTEC D	CIMETIDINE / TAGAMET	MUCINEX / (D)
ALLEGRA D	FAMOTIDINE/PEPCID	ZYFLO
CLARINEX D	RANITIDINE / ZANTAC	OTHERS_____

Inhalers

FLOVENT	ADVAIR	ALBUTEROL
PULMICORT	SYMBICORT	ALVESCO
QVAR	SEVEVENT	VENTOLIN
ASMANEX	FORADIL	PROAIR
PROVENTIL	XOPENEX	COMBIVENT
ATROVENT	SPIRIVA	OTHERS_____

Nasal sprays

NASONEX	RHINOCORT	PATANASE
NASACORT AQ	OMNARIS	FLONASE
VERAMYST	FLUTICASONE SPRAY	ASTELIN
ATROVENT	ASTEPRO	OTHERS_____

Please list any other medications you can think of that you have tried for these problems:

_____

EMR #: _____

Highlands Allergy and Asthma Center

PATIENT NAME: _____ DATE OF VISIT: _____

PART VI: YOUR PAST MEDICAL HISTORY (Do Not Include Family History Here)

Please circle YES or NO to indicate whether you have a past history of each medical condition.

Have you been tested for allergies before? YES NO When?_____ Physician?_____

Nasal allergies / Allergic rhinitis	YES	NO	Chronic kidney disease	YES	NO*
Non-allergic rhinitis	YES	NO	Acid reflux / GERD	YES	NO*
Frequent or chronic sinusitis	YES	NO	Hiatal hernia	YES	NO
Nasal polyps	YES	NO	Heart disease / blockage	YES	NO*
Asthma / Asthmatic bronchitis	YES	NO	High blood pressure	YES	NO*
Reactive airways	YES	NO	Diabetes (I have insulin)	YES	NO*
Exercise-induced asthma	YES	NO	Diabetes (I don't have insulin)	YES	NO*
Frequent or prolonged bronchitis	YES	NO	Rheumatoid arthritis or Lupus	YES	NO
Hives / Urticaria	YES	NO*	Connective tissue disease	YES	NO
Angioedema (sudden swelling)	YES	NO	Fibromyalgia	YES	NO
Anaphylaxis (severe allergic reaction)	YES	NO	Thyroid disease	YES	NO
Atopic dermatitis (childhood eczema)	YES	NO	Cancer	YES	NO*
Atopic dermatitis (adult)	YES	NO	Stroke / "mini-stroke" / TIA	YES	NO*
Pneumonia	YES	NO*	Migraine headaches	YES	NO*
Tuberculosis	YES	NO*	Root canal / dental infection	YES	NO
HIV / Aids	YES	NO	Dentures	YES	NO
Hepatitis	YES	NO	Glaucoma	YES	NO
Chronic liver disease	YES	NO*	**Are you pregnant?**	YES	NO*

PART VII: PREVIOUS SURGERIES

Please circle YES or NO to indicate whether you have a past history of each surgery.

Tubes in ears	YES	NO	Tubal ligation or similar	YES	NO*
Sinus surgery (any)	YES	NO*	Hysterectomy	YES	NO
Nasal surgery (any)	YES	NO*	Gall bladder	YES	NO
Nasal polyp removal	YES	NO	Tonsillectomy	YES	NO
Adenoidectomy	YES	NO			

Please list any other surgeries you have had: _____

_____

EMR #: _____

Highlands Allergy and Asthma Center

PATIENT NAME: _____ DATE OF VISIT: _____

PART VIII: YOUR FAMILY HISTORY

Please circle YES or NO to indicate whether you have a family history of these conditions.

Allergic rhinitis / nasal allergies	YES	NO*	Immune deficiency	YES	NO*
Chronic nasal problems (undiagnosed)	YES	NO	Cystic fibrosis	YES	NO*
Asthma / asthmatic bronchitis	YES	NO*	Food allergy	YES	NO
Emphysema	YES	NO	Chronic hives / urticaria	YES	NO
Atopic dermatitis (childhood eczema)	YES	NO*	Anaphylaxis (severe allergic reaction)	YES	NO
Angioedema / sudden swelling	YES	NO*			

Indicate any other family history you think is relevant: _____

_____

PART IX: YOUR ENVIRONMENT AND PERSONAL HISTORY

Please answer each question. If none, write "None."

SMOKING: Do you smoke NOW? YES NO Did you ever smoke in the past? YES NO

How many years did you smoke? _____ When did you quit? _____

Does anyone smoke in your home (primary home): YES NO SMOKES OUTDOORS ONLY

Are you frequently exposed to second hand smoke? YES NO

Does your home have CENTRAL A/C? YES NO Window AC unit(s)? YES NO

ALCOHOL: Do you drink alcohol? YES NO More than 2 drinks per day? YES NO

CAFFEINE: Do you drink caffeine? YES NO

DRUGS: Do you use recreational prescription or nonprescription drugs? YES NO

ANIMALS: List your indoor pets: _____

List your outdoor pets: _____

List animals you are frequently exposed to: _____

Circle any other exposures: HORSES CATTLE BARN MICE COCKROACH

HOBBIES: List hobbies (yours or others in home) that expose you to dust or fumes: _____

_____

WORK / SCHOOL / OTHER: Are there any other concerns about your environment, such as mold or chemical exposure? _____

_____

EMR #: _____

Highlands Allergy and Asthma Center

PATIENT NAME: _____ DATE OF VISIT: _____

PART X: OTHER

Please indicate any other history or concerns you think may be important: _____

_____

_____

_____

_____

_____

_____

For nurses' use:

BP _____ HR _____/ min Ht _____ in Wt _____ lbs Temp _____ °F

Respirations/min _____ O2sat _____% on _____ PEF _____L/min

FEV1_____L ACT _____

FINANCIAL POLICY

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

1. **PAYMENT** is expected at the time of your visit. Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. ***We will accept cash, check, debit, credit or health savings accounts***. You may also make a payment online through our patient portal, FollowMyHealth®.

   Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause payment in full is expected at the time of your visit. For visits under a "global" or a follow up trauma visit (from a procedure performed by an HMG physician) or for ongoing rehabilitation treatment plans, you will only be responsible for your co-payment if applicable based on your insurance. We do ask for a ***copy of your current insurance card*** at the time of your visit to ensure we properly file your claim.

2. **SURGERY PATIENTS:** You may be responsible or required to pay a percentage of surgery charges prior to any surgeries or procedures. This will be determined by information given to us by your insurance company in regard to patient percent responsibility.

3. **INSURANCE:** We participate with several insurance plans and will file your claims on your behalf. It is your responsibility to ensure coverage for services prior to your visit. You will be responsible for the complete charges for any non-covered services provided. In addition, all co-payments, deductibles or non-covered charges will be due at the time of service.You must provide proof of insurance at each visit so we can ensure proper billing to your benefit plan. If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance(s). We do not bill third party payors, but will be happy to provide a copy of the original claim if requested.

4. **HIGH-DEDUCTIBLE PLANS:** Under these plans, your insurance company will provide you a discount off our billed charges, but you are responsible for the entire amount due until you meet your deductible. ***We will accept cash, check, debit, credit or you may use your health savings account***.

5. **RETURNED CHECKS** will incur a $30.00 service charge.

6. **ACCOUNTING PRINCIPLES:** If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance (s). Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service

7. **FORMS FEES:** Medical records, except those involving worker's compensation cases, will be billed at the rates listed below:

   Simple Forms (completed within 2 business days)
   DURING an office visit: No Charge
   AFTER an office visit: $5 / form
   Examples of Simple Forms: Handicap tag/sticker, work re-entry forms, immunization, medication, sports, concussion clearance, WIC, Home Bound Status Short form, Disability Short Form, Bank Loan Form, Foster Parent Health Form, College & Camp Forms

   Complex Forms: $25 (completed within 10 business days)
   Examples of Complex Forms: FMLA (per illness per year), Disability Long Form, Home Bound Status Long Form.

FINANCIAL POLICY

8. **MISSED APPOINTMENTS:** If you fail to cancel a previously scheduled appointment at least 24 hours in advance, you may be charged a fee as outlined below:

- Established office visit: $20
- Allergy Testing: $75
- New patient visit or consultation: $100
- GI Procedure: $250

This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts. This charge is not applicable to patients with Medicaid/TennCare insurance coverage.

After 2 no-show appointments in a rolling calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

9. **UNPAID BALANCES:** All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency and could affect your credit.

10. **FINANCIAL DISMISSAL**: Patients who do not make payment arrangements risk being dismissed from the practice. Holston Medical Group reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

11. **BILLING QUESTIONS:** We will be happy to help you resolve your balance and can be reached at **(423) 578-1802, Monday – Friday 8:00AM – 5:00PM.**

HMG
HOLSTON MEDICAL GROUP

FINANCIAL POLICY

MRN#: _____

Date Received: _____

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

I have read, understand and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service are my responsibility.

I authorize Holston Medical Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Holston Medical Group.

By signing below, I indicate my agreement with the policy as provided to me.

_____	_____	_____
Date	**Signature**	**Printed Name**

HMG
HOLSTON MEDICAL GROUP

Seasons

MRN: _____

Date Received: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices,* which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

_____ _____

Print Patient Name | Patient Date of Birth

_____ _____

Patient Signature (if applicable) | Date

_____ _____

Authorized Representative Signature | Relationship to Patient

---

I understand that my Protected Health Information (PHI) will only be <u>verbally</u> communicated to those individuals listed below and no paper copies of my PHI will be provided without my signature on an *Authorization for Release of Individually Identifiable Health Information* form. I understand that some information may be considered sensitive, including but not limited to pregnancy test results, testing for sexually transmitted infections, Urine Drug Screen results, laboratory test results, medication, or information discussed during an office visit. The individuals listed below, will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individual(s) that you want protected health information verbally discussed with:

Name	Phone Number	Name	Phone Number

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained: _____

_____ _____

Employee Signature | Date

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.

Atención: Si necesita servicios de idioma o traducción, solicite hablar con el Gerente de Oficina

نبيه: إذا كنت بحاجة إلى خدمات اللغة أو الترجمة، فيرجى طلب التحدث مع مدير المكتب

HMG
HOLSTON MEDICAL GROUP

Patient: _____

MRN: _____

Communicating with Your Specialist

Access to Your Physician and Staff

Your Holston Medical Group (HMG) health care team can be reached either by telephone or electronically through our patient portal, FollowMyHealth®. If you wish to communicate electronically, you may sign up at any office location on our website at your convenience. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **is not** appropriate to communicate with your health care team through social media, such as **Facebook**, or **texting**. Your privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

After Hours Care

HMG is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. Your Primary Care Provider's telephone message will direct you on how to contact the HMG Physician on Call.

HMG Urgent Care

Please use the Emergency Room only in a true emergency (i.e. chest pain, shortness of breath, stroke-like symptoms).

To avoid long wait times in the ER, come to our Urgent Care clinics for routine health concerns such as colds, ear aches, flu symptoms, sprains and strains, etc. We have two locations conveniently located in Bristol and Kingsport. For hours and specific information call (423) 230-2420 (Kingsport) or (423) 990-2466 (Bristol).

Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 48 hours for all refill request before checking with your pharmacy.

Sample medication will only be distributed during normal business hours.

Monthly refills of any controlled medications (pain medication, anxiety, etc) will only be given during an office visit within regular business hours.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
ان ﺗﺤﺪث اﻟﻰ اﻟﻤﺪﻳﺮ ﻣﻦ ﻓﻀﻠﻚ ،ﺗﺮﺟﻤﺔ اﻟﻰ أو ﻟﻐﺔ ﻟﻠﺨﺪﻣﺎت ﺣﺎﺟﺔ ﻟﺪﻳﻚ ﻛﺎن إذا: ﻣﻼﺣﻈﺔ.

DIRECTIONS

Highlands Allergy & Asthma Center
933 Hwy 126
Bristol, TN 37620

Coming from Kingsport – Take 81 North to Bristol – turn (R) at exit 74-A – Bristol State Street – go past the entrance to Bristol Regional Medical Center – at the next red light turn (R) on to Hwy 126 West - Blountville Hwy (there is a CVS Pharmacy on (R) as you turn so you will know that you are in the right area). Go 1.4 miles – office on (R) beside J & G Auto Shop. Sign in parking lot – Highlands Allergy & Asthma

Coming from Kingsport – 11W to Bristol – go past entrance to Bristol Regional Medical Center – at the next red light turn (R) on to Hwy 126 West – Blountville Hwy (there is a CVS Pharmacy on (R) as you turn so you will know that you are in the right area). Go 1.4 miles – office on (R) beside J & G Auto Shop. Sign in parking lot – Highlands Allergy & Asthma

Coming from Blountville – take Hwy 126 to Bristol - go past Sullivan County Court House – approximately 10 miles. Office will be on the (L) beside entrance to Collingwood Subdivision. Sign in parking lot – Highlands Allergy & Asthma

Coming from Johnson City, Piney Flats, or Bluff City – take 394 to Bristol – turn (R) on to Hwy 126 to Bristol – go approximately 10 miles. Office will be on (L) beside entrance to Collingwood Subdivision. Sign in parking lot – Highlands Allergy & Asthma

Coming from Abingdon & VA area – take 81 South to exit 74-A Bristol State Street – go past the entrance to Bristol Regional Medical Center at the next red light turn (R) on to Hwy 126 West – Blountville Hwy (there is a CVS Pharmacy on (R) as you turn so you will know that you are in the right area). Go 1.4 miles – office on (R) beside J & G Auto Shop. Sign in parking lot – Highlands Allergy & Asthma
(423) 844-7000