Patient Information

ALLERGY PARTNERS

First _____ MI_____ Last_____

Prefers to be called_____ Date of Birth ____/_____/_____ Age ____ Marital Status: _____
Married/ Single/Divorced/Widowed/Other

Address Primary _____ City _____ State_____ Zip _____

Alternate Address _____ City _____ State_____ Zip _____

Phone #1 _____ Phone #2 _____ Phone #3 _____
Home/Cell/ Work Home/Cell/ Work Home/Cell/ Work

Email address _____ Preferred method of contact: Letter Phone call Email Other_____

Sex____ SS # _____Referring Physician _____Primary Care Physician_____
M F

Preferred Language _____ Race: _____Ethnicity: _____
Non-Hispanic or Latino/Hispanic or Latino/other or Undetermined

Referred by: ☐doctor ☐self ☐family/friend ☐internet ad ☐internet search ☐yellow pages ☐ radio ☐TV ☐ Other _____

Occupation_____Employer_____Is this visit related to a work injury? Y N

Current Pharmacy Name and Location _____

Emergency Contact

Name _____Phone # _____Relationship to patient_____

Responsible Party/Guardian/Guarantor ☐ Address Same as Patient

Name_____ Address_____ _____ City_____ State ___ __Zip_____

Home# _____ Cell # _____ Business # _____

SS#_____ Patient's Relationship to Guarantor_____ DOB ____/____/____ ____

Sex _____ Occupation_____ Employer _____

Primary Insurance Information ☐ Address Same as Patient

Name of Ins.Co. _____ ID # _____Group #_____Group Name_____ Policy

Holder Name _____DOB ____/____/_____Relationship to Patient _____ _____

Address_____ ___ City_____ State_____ Zip_____ Phone #_____

SS# _____ Sex_____ Occupation_____ Employer _____

Secondary Insurance Information ☐Address Same as Patient

Name of Ins.Co. _____ID # _____Group# _____Group Name _____

Policy Holder Name _____ DOB ____/____/_____Relationship to Patient_____

Address_____City_____ State. _____Zip_____Phone# _____

SS# _____Sex_____Occupation_____Employer_____

List any person(s) to whom you will allow access to your medical records

Name/Relationship_____Name/Relationship_____

I hereby authorize the office of Allergy Partners, P.A .to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payor to pay directly to Allergy Partners, P.A. for services rendered. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

I acknowledge that I have received a copy of Allergy Partners, P.A. Notice regarding Privacy of Personal Health Information (PHI). I understand that Allergy Partners, P.A. may request a medication history from my pharmacy as part of my treatment plan, and I hereby give my consent for such requests.

Patient name _____Signature_____ Date _____
OR
Responsible party_____Signature_____ Date _____

Medical services provided by Allergy Partners, P.A.

ALLERGY PARTNERS

FINANCIAL POLICY

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies or your insurance coverage and your financial responsibilities

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education and training and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

Patient Payments: Co-pays, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. Payments may be made with cash, check or credit card. Returned checks will be subject to the fee allowed by state regulations. Please let us know if you are having a particular financial problem and we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our in house Financial Coordinator or our Central Billing Office.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays.

Additional Fees:

Missed Appointments: Please understand that when you reserve an appointment with one of our physicians, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. To assist all of our patients with appropriate access to our physicians we may charge a fee for any office visit appointment cancelled with less than 24 hours notice. Please note this fee is not covered by your insurance company.

Medical Supplies: Please note that certain medical supplies given to you at your visit require an advanced payment from you at check out. We will submit any charges for medical supplies to your insurance company, and we will reimburse you the payment difference made by your insurance company.

Medical Forms: The completion of disability forms, attending physician statements and other supplemental insurance forms all require physician and staff time to complete. Accordingly, a fee may be charged to complete most of these forms. Non-standard forms may be higher.

Nurse Visit: Please note that if a patient comes in without an appointment to speak to a nurse, depending on the time and complexity of the visit, there may be a charge for the visit.

_____ _____

Signature of Responsible Person Date

ALLERGY PARTNERS

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION

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.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) requires that the Practice provide you with this Notice Regarding Privacy of Personal Health Information. The Notice describes (1) how the Practice may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the Practices' duties and contact information.

I. Protected Health Information

"Protected Health Information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present, or future mental health; the provision of health care to your; and your past, present, or future payment for healthcare.

II. The Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Operations.

Your protected health information may be used and disclosed by the Practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The practice may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The Practice may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the Practice may coordinate your health care with a third party. For example, the Practice may disclose your protected health information to a pharmacy to fulfill a prescription, to an X-ray facility to order and X-ray, or to another physician who is administering allergy shots, which we prepared. In addition, the Practice may disclose protected health information to other physicians or health care providers for treatment activities of those other providers.

Payment. When needed, the Practice will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended treatment or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, the Practice may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, the Practice may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Healthcare Operation. The Practice may use or disclose your protected health information when needed for the Practice's health care operations for the purposes of management or administration of the Practice and of offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, credentialing activities: (4) review and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, the Practice may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the Practice may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures. As part of treatment, payment, and healthcare operations, the Practice may also use or disclose your protected health information to: (1) remind you of a appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

III. Additional Uses and Disclosures Permitted Without Authorization or an Opportunity to Object

In addition to treatment, payment, and health care operations, the Practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The Practice will comply with any Federal, state or local law that requires it to disclose your protected health information.

When There Are Risks to Public Health. The Practice may disclose your protected health information for public health purposes, included to, as permitted or required by law:

(1). Prevent, Control, or report disease, injury or disability;
(2). Report vital events such as birth or death;
(3). Conduct public health surveillance, investigations, and interventions;
(4). Collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements, and conduct post marketing surveillance;
(5). Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease; and
(6). Report to an employer information about an individual who is a member of the workforce.

To Report Abuse, Neglect, or Domestic Violence. As required or authorized by law with the patient's agreement, the Practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect, or domestic violence.

To Conduct Health Oversight Activities. The Practice may disclose your protected health information to a health oversight agency for use in (1) audits; (2) civil, administrative, or criminal investigations, proceedings or actions; (3) inspections; (4) licensure or disciplinary actions; or (5) other necessary oversight activities as permitted by law. However, if you are the subject of an investigation, the Practice will not disclose protected health information that is not directly related to your receipt of health care or public benefits.

For Judicial and Administrative Proceedings. The Practice may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by such order or a signed authorization is provided.

For Law Enforcement Purposes. The Practice may disclose your protected health information to a law enforcement official for law enforcement purposes when:

(1). Required by law to report certain types of physical injuries;
(2). Required by court order, court-ordered warrant, subpoena, summons, or similar process;
(3). Needed to identify or locate a suspect, fugitive, material witness, or missing person;
(4). Needed to report a crime in an emergency situation;
(5). You are the victim of a crime in specific limited instances; and
(6). Your death is suspected by the Practice to be the result of criminal conduct.

To Coroners, Funeral Directors, and for Organ Donation. The Practice may disclose protected health information to a coroner or medical examiner for the purpose of (1) identification, (2) determination of cause of death, or (3) performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the Practice may disclose protected health information, including when death is reasonably anticipated, to a funeral director to enable the funeral director to carry out his or her duties. Protected health information may also be used and disclosed for the purpose of cadaveric organ, eye or tissue donation.

For Research Purposes. The Practice may use or disclose your protected health information for research if such use or disclosure has been approved by an institutional review board or privacy board that has examined the research proposal and the research protocols which maintain the privacy of your protected health information.

To Prevent or Diminish a Serious and Imminent Threat to Health or Safety. If in good faith the Practice believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to your health or safety or to the health and safety of the public, the Practice may use or disclose your protected health information as permitted under law and consistent with ethical standards of conduct.

For Specified Government Functions. As authorized by the HIPAA privacy regulations, the Practice may use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Workers Compensation. The Practice may disclose your protected health information to comply with worker's compensation laws or similar programs.

IV. Uses and Disclosures Permitted With an Opportunity to Object

Subject to your objection, the Practice may disclose your protected health information to (1) a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care; or (2) when attempting to locate or notify family members or others involved in your care to inform them of your location, condition or death. The Practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not object to these disclosures, the Practice is able to infer from the circumstances that you do not object, or the

Practice determines, in its professional judgment, that I is in your best interests for the Practice to disclose information that is directly relevant to the person's involvement with your care, the then Practice may disclose your protected health information. If you are incapacitated or in an emergency situation, the Practice may exercise its progression judgment to determine if the disclosure is in your best interests and, if such a determination is made, may only disclose information directly relevant to your health care.

V. Uses and Disclosures Authorized by You

Other than the circumstances described above, the Practice will not disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice have taken action in reliance upon the authorization.

VI. Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information. For as long as the practice holds your protected health information, you may inspect and obtain a copy of such information included in a designated record set. A "designated record set" contains medical and billing records as well as any other records that your physician and the Practice uses to make decisions regarding the services provided to you. The Practice may deny your request to inspect or copy your protected health information if the Practice determines in its professional judgment that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition you may not inspect or copy certain records by law, including: (1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and (2) protected health information that is subject to a law that prohibits access to protected health information. You may have the right to have a decision to deny access reviewed in some situations.

You must submit a written request to the Practice's Privacy Officer to inspect and copy your health information. The Practice may charge you a fee for the costs of copying, mailing, or other costs incurred by the Practice in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record at the number given on the last pages of this Notice.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the Practice not use or disclose specific sections of your protected health information for the purposes of treatment, payment, or health care operations. Additionally, you may request that the practice not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the Practice's Privacy Officer.

The Practice may choose to deny your request for a restriction, in which case the Practice will notify you of its decision. Once the Practice agrees to the requested restriction, the Practice may not violate the restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The Practice may terminate the agreement to a restriction in some instances.

The right to request to receive confidential communications from the Practice by alternative means or at an alternative location. You have the right to request that the Practice communicates with you through alternative means or at an alternative location. The Practice will make every effort to comply with reasonable requests. However, the Practice may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide and explanation for your request. Requests should be made in writing to the Practice's Privacy Officer.

The right to request an amendment of your protected health information. During the time that the Practice holds your protected health information, you may request an amendment of your information in a designated record set. The practice may deny your request in some instances. However, should the Practice deny your request for amendment, you have the right to file a statement of disagreement with the Practice. In turn, the Practice may develop a rebuttal to your statement. If it does so, the Practice will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Practice's Privacy Officer.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the Practice's disclosures of your protected health information made for purposes other than treatment, payment or health care operations as described in this Notice. The Practice is not required to account for disclosures (1) which you requested, (2) which you authorized by signing an authorization form, (3) for a facility directory, (4) to friends or family members involved in your care, and (5) certain other disclosures the practice is permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer and should state the time period for which you wish the accounting to include, up to a sex year period. The Practice is not required to provide an accounting for disclosures that take place prior to April 14, 2003. The Practice will not charge you for the first accounting you request of any 12 month period. Subsequent accountings may require a fee based on the Practice's reasonable costs for compliance of the request.

The right to obtain a paper copy of this Notice. The Practice will provide a separate paper copy of this Notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

VII. The Practice's Duties

The Practice is required to ensure the privacy of your health information and to provide you with this Notice of your rights and the Practice's duties and procedures regarding your privacy. The Practice must abide by the terms of this Notice, as may b e amended periodically. The Practice reserves the right to change the terms of the Notice and to make the new Notice provisions effective for all protected health information that the Practice collects and maintains. FI the Practice alters its Notice, the Practice will provide a copy of the revised Notice through regular mail or in-person contact.

VIII. Complaints

If you believe that your privacy rights have been violated, you have the right to relate complaints to the Practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the Practice verbally or in writing. Such complaints should be directed to the Practice's Privacy Officer. The Practice encourages you to relate any concerns you may have regarding the privacy of your information and you will be retaliated against in any way for filing a complaint.

IX. Contact Person

The Practice's contact person regarding the Practice's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this Notice by request. Complaints to the Practice should be directed to the Privacy Officer at the following address:

Denise C. Yarborough
Allergy Partners P.A.
PO Box 2407
Skyland, NC 28776

The Privacy Officer can be contacted by telephone at: (828) 277-1300

X. Effective Date

This notice is effective on April 14, 2003.

ACKNOWLEDGEMENT

I, _____ (patient/guardian) acknowledge that I have received a copy of Allergy Partners, P.A. d/b/a _____'s **Notice Regarding Privacy of Personal Health Information.**

Date: _____ _____

(Patient/Guardian Signature)