ALLERGY ASTHMA CLINIC, LTD **NEW PATIENT INFORMATION**

Welcome to our practice!

Thank you for choosing Allergy Asthma Clinic, Ltd for your allergy/immunology needs. We are committed to building a successful physician – patient relationship with you and your family. The information below is provided to assist you with your experience at our office.

New Patient Visit: Before seeing a physician, all new patients are required to review and complete the following forms:

- Patient Information Form
- Billing/Financial Policy
- Release and Authorization for use or disclosure of Protected Health Information (PHI)
- Notice of Privacy Practices

What to Bring to Your Appointments:

- Current insurance card
- Current ID
- Form of payment (credit/debit card, cash) to cover the fees payable at the time of service, including copays, unmet deductible and co-insurance

Allergy Testing Patients: In order for us to perform an allergy test, you must NOT be on any antihistamines for 72 hours prior to your appointment. Please, refer to our "Medications to Avoid Prior Allergy Testing" form for details.

Referrals: If your insurance requires a referral, please make sure this has been called into your primary care physician. If a referral is required and we do not have this information on the date of your visit, your appointment may need to be rescheduled.

Check–in Time: For your first visit, we ask that you arrive 15 minutes prior to your appointment in order to take care of the necessary paperwork. For your follow-up appointments and check-ups, please arrive 10 minutes before the check-in time.

Late Arrival Policy: We understand that our patients have busy schedules, and we will try to accommodate anyone that arrives late to their appointment. Unfortunately, such accommodation might not be always possible, and we might need to ask you to reschedule your appointment. Please, do your best to be on time. Thank you.

Missed Appointments/Cancellations: Any missed appointment or rescheduled within 24 hours of the check-in time will result in a $40 deposit for any future appointment scheduled. The deposit is non-refundable.

Copays and deductibles: Your insurance company requires us to collect copayments and deductibles at the time of service. We may need to reschedule your appointment if you do not have your copay at the time of service. You are also required to pay your deductible at the time of service or set up a payment plan with our billing department prior to your visit. Our billing department number is 602 277 3525.

It is a patient's responsibility to know their benefits. Please, contact your insurance company for details.

Authorization for medical treatment of a minor: Patients under the age of 18 must be accompanied by a parent/legal guardian. The person bringing in the child for medical treatment will be held responsible for payment at the time of service.

Thank you for choosing Allergy Asthma Clinic, Ltd for your allergy/immunology needs!

ALLERGY ASTHMA CLINIC, LTD

BILLING AND FINANCIAL POLICY

Welcome to Allergy Asthma Clinic, Ltd. We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care. The information below was designed to provide our patients with a detailed explanation of our billing and financial policies.

Identification: For the protection of our patients, in order to reduce medical identity theft, all patients are required to present valid insurance card and driver's license at every visit. If a driver's license is unavailable, a valid photo ID must be presented. It is also the patient's responsibility to make sure that our office has their updated address, phone and email information.

Proof of Insurance: Patients are responsible for providing Allergy Asthma Clinic with the correct insurance information at each visit. If you fail to do so, you might be responsible for payment for all services provided.

Your health insurance contract is between you and your insurance company. Knowing your insurance benefits is your responsibility. Our billing company will verify your benefits, as a courtesy, however the verification is not a guarantee of payment. Insurance carriers have the final say regarding all coverage decisions. Please, contact your insurance company if you have any questions or concerns.

Referrals/Authorizations: If your insurance requires a referral, please make sure this has been called into your primary care physician. If a referral is required and we do not have this information on the date of your visit, your appointment may need to be rescheduled.

Forms Completion. Completion of forms for insurance purposes, such as application for insurance coverage, disability or FMLA leave requires setting up an appointment with a provider.

Payment policies:

- **Insured Patients.** All copays must be paid at the time of service. You are also required to pay your deductible or set up a payment plan with our billing department prior to your visit. Our billing department number is 602 277 3525. If you decide to refrain from inquiring with the billing department about the cost of services prior to your appointment, it is understood that you have no concerns/issues with the out-of-packet cost involved.
  If you're unable to pay your copay at the time of service, your appointment may be rescheduled.

  Any questions regarding billing must be directed to the billing department. Please, do not ask other staff members (front desk staff, nurses, physicians, etc.) regarding the billing of your services. Information provided from sources outside the billing department is not applicable.

- **Non-Insured Patients/Self-Pay Patients.** Allergy Asthma Clinic requires full payment at the time of service unless prior arrangements have been made with our billing department. Our billing department number is 602 277 3525.
  A 25% discount is offered for payment in full on the date of the visit.

- **Non-Covered Services.** Patients are responsible for services deemed non-covered by their insurance carrier and full payment is required at the time of service.

- **Balances outstanding.** Patient balances after insurance payments must be paid in full within 60 days of the first statement.

- **Outside collections.** Balances that remain unpaid after 90 days, with no payment arrangement, are considered delinquent and subject to debt collection. If you are unable to remit the entire balance due within this 90-day period, please call our billing department at 602 277 3525 to arrange a payment plan. Failure to contact us and setting up a payment plan may result in your account being turned over to an outside collection agency. At that time a fee equal to 30% of the delinquent amount will be assessed to your balance. Non-payment of account balance may result in the severing of the patient/doctor professional relationship.
  Delinquent balances must be paid prior to new services being rendered.

- **Bankruptcy.** If an account is uncollectable due to bankruptcy, future services must be paid in full at the time of service.

- **Missed or Canceled Appointments.** Any missed appointment or rescheduled within 24 hours of the check-in time will result in a $40 deposit for any future appointment scheduled. The deposit is non-refundable.

- **Financial Responsibility for Minor Children of Separated or Divorced Parent.** Allergy Asthma Clinic Ltd. will not be a party to separation/divorce billing disputes. The parent or legal guardian, who requests and consents to the treatment of a child, will be responsible for the payment of services rendered.

- **Immunotherapy Balances** (Applies to patients receiving allergy injections). Any unpaid balance must be paid in full prior to the renewal of your next 6-month supply of Extract.

CREDIT CARD ON FILE POLICY

To streamline our payment system and provide a seamless, convenient way for patients to pay their bills, Allergy Asthma Clinic Ltd. (AAC) requires all patients keep an active credit card on file with us.

Here's how it works:

1. To keep your information safe and secure, we are working with Instamed, an off-site, HIPAA-compliant, third-party company that securely stores and processes credit card, debit card, or health insurance card information. For your protection, only the last 4 digits of your credit card are visible to our staff. Instamed has been our partner in credit card processing since 2021. Many patients have already participated in our "Credit card on file" program on voluntary basis during that time.
2. When you come in for your appointment or allergy injection, we will simply swipe your card into Instamed software. It will be on file for future use or to pay off any outstanding balances.
3. Once your claim is submitted and processed by your insurance company, an Explanation of Benefits (EOB) will be mailed by them to both you and our office showing what your total patient responsibility is. **Typically, patients receive their EOBs before we do, so if you disagree with the patient amount owed, it is your responsibility to contact your insurance carrier immediately.**
4. Our practice will charge your card for any balances your insurance company determines as patient responsibility (deductible, copay, co-insurance, etc). We also reserve the right to charge it for any balances stemming from missed appointments or shipping serum if applicable. If we have your email on file, a payment receipt will be emailed to you. Pre-verified balances are due on the day of service.
5. It is your responsibility to ensure that the card we have on file is not expired or cancelled and has an appropriate amount of available credit. Please call our office immediately if you need to update your credit card information.

Rest assured, this program in no way hinders your ability to dispute a charge or question your insurance company about their determination of payment. And any amount credited to your account will be refunded to the card on file.

I authorize AAC to capture my credit card information and to charge it as payment for any balance put into the patient's responsibility because of my insurance plan's deductible, co-insurance or co-payment. I certify that I am an authorized user of this credit card, and I agree that this form is valid until I give a 30-day written notice to cancel the authorization to AAC, Attn: Billing Dept., 300 W Clarendon Ave #120 Phoenix, AZ 85013

Patient Name: _____

Cardholder Name: _____ Last 4 digits of Credit Card:_____

CVV Code:_____ Billing Zip Code:_____ Expiration date:_____

Billing Address:_____

Cardholder Signature:_____ Date:_____

ALLERGY ASTHMA CLINIC, LTD NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create and maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Allergy Asthma Clinic, Ltd
Compliance Administrator
300 W Clarendon Ave Suite 120
Phoenix, AZ 85013

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

1. **Treatment.** Our practice may use your PHI to treat you. Many of the people who work for our practice, including but not limited to nurses and doctors, may use or disclose your PHI in order to treat you or assist others in your treatment.
2. **Payment.** Our practice may use or disclose your PHI in order to bill and collect payment for the services and items you may receive from us.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business, for example to evaluate the quality of care you received from us, or to conduct cost management or business planning activities for our practice.
4. **Appointment Remainders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment. We will notify you about your appointment via personal call, email or text. The notification may involve leaving a message on an answering machine or other automated or electronic equipment for such purposes, which could (potentially) be received or intercepted by others.
5. **Sign in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives as well as of health-related benefits that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your PHI to the responsible party you identify.
8. **Marketing.** We will not use or disclose your medical information for marketing purposes without your prior written authorization.
9. **Sale of Health Information.** We will not sell your health information.
10. **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

11. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law.

D. USE AND DISCLOSURE OF PHI IN SPECIAL CIRCUMSTANCES.

The following categories describe unique scenarios in which we may use or disclose your PHI:

1. **Public Health Risk Reporting.** Our practice may disclose your PHI to public health authorities.
2. **Law Enforcement.** Your health information may be disclosed to law enforcement agencies, military and national security without your permission, to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.
3. **Workers' Compensation.** Our practice may release your PHI for worker's compensation and similar programs that provide benefits for work-related injuries and illness.

E. YOUR RIGHTS REGARDING YOUR PHI.

You have the following rights regarding the PHI that we maintain about you. These include:

- The right to request restrictions on the use and disclosure of your PHI, including to request that a health plan not be informed of treatment for which patient paid entirely out of pocket.
- The right to prohibit the sale of your PHI, its use for marketing purposes or participation in research.
- The right to request confidential communication concerning your medical condition and treatment in a specific manner.
- The right to inspect and obtain copies of your PHI.
- The right to amend or submit corrections to your PHI
- The right to receive an accounting of how and to whom your PHI has been disclosed outside of our practice if not for treatment, payment or health care operations.
- The right to file a complaint if you believe your privacy rights have been violated. Please, file your complaint in writing. You will not be penalized for filing a complaint.
- The right to receive a printed copy of this notice.

All requests must be in writing and directed to Allergy Asthma Clinic. Compliance Administrator at 300 W Clarendon Ave, Suite 120, Phoenix, AZ 85013. Our practice may charge a fee for the costs associated with any requests.

F. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you believe your privacy rights have been violated, you may complain to the secretary of the U.S. Department of Health and Human Services or to the Compliance Administrator listed below. There will be no retaliation against you for filing a complaint. Again, if you have any questions regarding this Notice or our health information privacy policies, please contact:

Allergy Asthma Clinic, Ltd
Compliance Administrator
300 W Clarendon Ave Suite 120
Phoenix, AZ 85013

ALLERGY ASTHMA CLINIC, LTD

PATIENT REGISTRATION FORM

PATIENT NAME: _____ SS#_____ DOB: _____
(LAST) (FIRST) (MI)

GENDER: MALE FEMALE Address: _____
Street City State Zip

HOME: (_____) _____ CELL: (_____) _____ Can we leave a message? Y N

EMAIL: _____ _____ Preferred Communication? Cell Home Email

EMPLOYER: _____ OCCUPATION: _____ WORK: (_____) _____

EMERGENCY CONTACT: _____ DOB: ___/___/_____PHONE: _____ Relationship: _____

RACE/ETHNICITY/LANGUAGE (REQUIRED BY HEALTHCARE REFORM)

ETHNICITY: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to specify Primary Language: _____

RACE: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Caucasian □ Decline to specify

MARITAL STATUS: S M W D

(If patient is under 18 years old):

Mothers Name: _____ DOB: _____ SS #: _____Phone: _____

Fathers Name: _____ DOB: _____ SS #: _____ Phone: _____

Primary Care Physician: _____ Phone: (_____) _____

Would you like us to send a letter to your PCP? Yes No Fax: (_____) _____

Referring Physician: _____ Phone: (_____) _____

Address: _____ Fax: (_____) _____

***Pharmacy**: _____ **Crossroads:** _____ **Phone**: (_____) _____

INSURANCE INFORMATION

Primary Insurance: _____

Name of Policy Holder: _____

Relationship to Patient: □ Self □ Spouse □ Parent

Gender: □ Male □ Female DOB: _____

Employer: _____

Secondary Insurance: _____

Name of Policy Holder: _____

Relationship to Patient: □ Self □ Spouse □ Parent

Gender: □ Male □ Female DOB: _____

Employer: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Allergy Asthma Clinic, Ltd to release any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Allergy Asthma Clinic, Ltd for medical care rendered to my dependents or myself. I understand I am responsible for amount not covered by insurance.

Signature: _____ Date: _____

ALLERGY ASTHMA CLINIC, LTD AUTHORIZATIONS AND ACKNOWLEDGEMENTS

Release of medical information (PHI):

[ ] I do not wish my medical information to be released to any significant other.

[ ] I request and authorize Allergy Asthma Clinic, Ltd to review and release my medical information to the following individuals (e.g. Spouse, Parent, Sibling, etc.)

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

What is the best way to reach you? cell/email/home _____

May we leave a message at home with a family member? [ ] Yes [ ] No

May we leave a voice message? [ ] Yes [ ] No

How would you like to receive your billing statement? [ ] electronically (email) [ ] paper (by mail)

Receipt of Notice of Privacy Practices (HIPAA):

I have received the Notice of Privacy Practices from Allergy Asthma Clinic, Ltd. It is also available in any of Allergy Asthma Clinic offices and on the practice website at www.allergyasthmaclinicltd.com

Receipt of notice of Billing and Financial Policy:

I have received the Billing and Financial Policy from Allergy Asthma Clinic, Ltd. It is also available in any of Allergy Asthma Clinic offices and on the practice website at www.allergyasthmaclinicltd.com

I have read and understand the terms above. Any changes to patient authorizations must be provided in writing to Allergy Asthma Clinic, Ltd.

_____ _____

PRINTED NAME OF PATIENT SIGNATURE

_____ _____

(IF MINOR CHILD PRINTED NAME OF RESPONSIBLE PARTY) DATE

ALLERGY ASTHMA CLINIC, LTD

PATIENT HISTORY

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

If you have a printed list of your medical history, please give to the front office to attach

MEDICATION ALLERGIES?: ____ NO ____ YES (If YES, please list below and describe reaction) *data input		

Please answer each of the following questions: *data input			
Smoking & Tobacco Use: (For ages 12 and older) __ Never Smoked __ Current every day smoker __ Current some day smoker __ Former smoker __ Exposed to secondhand smoke	**Alcohol Use (all ages)** __ Social drinker __ Daily drinker __ Former drinker __ Denies drinking	**Influenza/Flu (all ages)** Did you get your flu shot this year? ___ YES ___ NO	**Pneumovax (65 yrs & older)** Have you ever received a Pneumococcal vaccine? ____ YES ____ NO **For patients 65 yrs & older** **Do you have an advanced directive?** ____ YES ____ NO

CHECK ALL THAT APPLY:		
☐ ANXIETY	☐ DIABETES	☐ OSTEOPOROSIS
☐ ARTHRITIS	☐ GERD/HEARTBURN	☐ PROSTATE ENLARGEMENT
☐ ASTHMA	☐ GLAUCOMA	☐ SLEEP APNEA
☐ BRONCHITIS	☐ HEART DISEASE	☐ THYROID DISEASE
☐ CANCER: _____	☐ HIGH CHOLESTEROL	☐ OTHER: _____
☐ CHRONIC SINUS DISEASE	☐ HIGH BLOOD PRESSURE	☐ OTHER: _____
☐ COPD	☐ KIDNEY DISEASE	☐ OTHER: _____
☐ DEPRESSION	☐ MIGRAINE HEADACHES	☐ OTHER: _____

PREVIOUS MAJOR SURGERIES: (PLEASE CHECK ANY PROCEDURES YOU HAVE HAD)

☐ SINUS SURGERY _____ DATE: _____	☐ HERNIA SURGERY DATE: _____	☐ OTHER: _____
☐ TONSILLECTOMY _____ DATE: _____	☐ JOINT REPLACEMENT DATE: _____	☐ OTHER: _____
☐ THROAT SURGERY_____ DATE: _____	☐ HEART SURGERY DATE: _____	☐ OTHER: _____
☐ NASAL SURGERY _____ DATE: _____	☐ THYROID SURGERY DATE: _____	☐ OTHER: _____
☐ APPENDIX _____ DATE: _____	☐ GALL BLADDER DATE: _____	☐ OTHER: _____

CURRENT Rx MEDICATIONS: **If you have a printed list of meds, please give to the front office *data input		

ALLERGY ASTHMA CLINIC, LTD

ALLERGY TESTING - MEDICATIONS

Important Information about Allergy Skin Testing:

Patients scheduled for allergy skin testing must stop taking any medications that contain antihistamines as they will affect the results of the test. This includes both over-the-counter as well as prescription medications. **Do not discontinue antidepressants/psychotropic medications or any other medications without consulting with your prescribing physician.** Asthma medications do not affect skin testing. **Do not stop your asthma medications**.

MEDICATIONS TO STOP 72 HOURS PRIOR TO SKIN TESTING:

ACTIDIL	CETIRIZINE	DEXBROMPHENIRAMINE	ISOCLOR	XYZAL
ACTIFED	CHLOR-TRIMETON	DEXCHLORPHENIRAMINE	LORATADINE	ZYRTEC
ALAVERT	CHLORPHENIRAMINE	DIMETANE	NALDECON	ZYRTEC D
ALLEGRA	CLARITIN	DIMETAPP	OPTIMINE	
ALLEGRA D	CLARITIN D	DIPHENHYDRAMINE	ORAHIST	**SLEEP AIDS:**
ALLEREST	CLEMASTINE FUMARATE	DOXYLAMINE	ORNADE	ADVIL PM
ALLERGESIC	CLISTIN RONDEC	DRAMAMINE	PALGIC	TYLENOL PM
ALLERX	CLORPHERNIRAMINE	DRIXORAL	PATANASE	NYQUIL
ANTIVERT	COMTREX	DRISTAN	PERIACTIN	
ATROHIST	CONTAC	EXTENDRYL	PHENERGAN	
BENADRYL	CORICIDIN	FEDAHIST	POLARAMINE	
BENYLIN	CYCLOBENZAPRINE	FEXOFENADINE	POLYHISTINE	
BROMFED	CYPROHEPTADINE	FLEXERIL	PROMETHAZINE	
BROMPHENIRAMINE	DECONADE	FORMULA 44	RONDEC	
CARBINOXAMINE	DECONAMINE	HISTEX	RYNATAN	

MEDICATIONS TO STOP 5 DAYS PRIOR TO SKIN TESTING:

ATARAX	CLARINEX	CLARINEX D	HYDROXYZINE

GI MEDICATIONS (STOP 72 HOURS PRIOR SKIN TESTING):

AXID	FAMOTIDINE	PEPCID	TAGAMET
CIMETIDINE	NIZATIDINE	RANITIDINE	ZANTAC

ANTIHISTAMINE NASAL SPRAYS (STOP 72 HOURS PRIOR SKIN TESTING):

AZELASTINE	ASTEPRO	ASTELIN	DYMISTA	PATANASE

TRICYCLIC ANTIDEPRESSANTS (STOP 5 DAYS PRIOR SKIN TESTING):

AMITRIPTYLINE	DOXEPIN	NORTRIPTYLINE	TRIMIPGRAMINE
AMOXAPINE	IMIPRAMINE	PROTRIPTYLINE	
DESIPRAMINE	LIMBITROL	SEROQUEL	

EYE DROPS (STOP 72 HOURS PRIOR SKIN TESTING):

PATADAY	PATANOL	OLOPATADINE	OPTIVAR	ZADITOR (KETOTIFEN)