



Patient Information Form

Patient Name _____

Address _____

City _____ State _____ Zip _____

Phone#: Home _____

Cell _____

Work _____ Ext _____

Date of Birth _____ Gender _____

Employer _____

Primary Care/Referring Physician

Physician's Name _____

Phone # _____

How did you hear about our office? _____

Person Responsible for Bill (complete in full)

Self Spouse Guardian Parent Other

Name _____

Address _____

City _____ State _____ Zip _____

Phone#: Home _____

Cell _____

Work _____ Ext _____

Date of Birth _____

Employer _____

Insurance Information

My Plan is a: PPO HMO POS (Point of Service) Other

Primary Insurance Name _____

Name of Insured _____

D.O.B. _____

Member ID _____

Group # _____

Patient's relationship to primary insured:

self spouse child other

Secondary Insurance _____

Name of Insured _____

D.O.B. _____

Member ID _____

Group# _____

Patient's relationship to primary insured:

self spouse child other

Person to Contact in Case of Emergency

Name _____ Relationship _____

Phone#: Home _____

Cell _____

Work _____ Ext _____

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Your signature on this form acknowledges your receipt of the Notice.

I acknowledge that I have received a copy of the Allergy & Asthma Associates of Northern California's Notice of Privacy Practices.

Signature _____ Date _____

Authorization for Payment/Release of Medical Records

I authorize release of medical records and payment of my benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

Signature _____

Date _____



ALLERGY AND ASTHMA ASSOCIATES

OF NORTHERN CALIFORNIA

A MEDICAL CORPORATION

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. The following is a statement of our Financial Policy. We request that you read, agree to and sign below prior to treatment. All patients must complete our Registration Form, provide insurance information and present insurance card(s) and driver's license to be photocopied. If you do not have your insurance information at the time of your visit you will be personally responsible for the cost of services provided. Due to timely filing issues, we may be unable to submit your claim to your insurance carrier if we do not receive your insurance information within 10 business days following the date of your visit.

AAANC staff will submit your claim to your insurance carrier for payment. The balance after your insurance payment is received is your responsibility. All co-pays and deductibles are due at the time of service. Any balance on your account must be paid in full. Secondary insurance is billed as a courtesy to our patients. If your insurance company does not respond within 60 days, the balance will become your responsibility. All HMO plans require authorization from the assigned medical group. If an authorization is not obtained prior to your visit, charges are the responsibilities of the patient and are due at the time of the visit. Retroactive authorizations are not acceptable.

Services not covered by your insurance policy are your financial responsibility. Please note that testing may be subject to some plan limitations. Unless cancelled at least 24 hours in advance our policy is to charge \$50.00 for missed appointments. Please help us serve you better by keeping your scheduled appointment.

The purpose of the Financial Policy is to clarify any questions you may have about your financial obligation to Allergy & Asthma Associates of Northern California. If the account becomes delinquent (not paid according to the above-stated policy), the doctor, his assigns, or lawful agents may pursue collection procedures. Thank you for understanding our Financial Policy. If you have questions about our policy, please ask before services are rendered.

I have read, understand and agree to the provisions of this Financial Policy. By signing below I agree and understand that the benefits quoted are not a guarantee of coverage and should the benefit coverage change I assume complete financial responsibility for my and/or my dependent(s) medical care. I understand that I will be responsible for all collection costs, including but not limited to court filing fees, service of process costs, interest and attorney fees should my and/or my dependent(s) account become delinquent.

Signature of Responsible Party

Date

Print name of Responsible Party

Signature of Authorized Representative of Allergy & Asthma Associates

Date

CONSENT TO TREATMENT :

The undersigned hereby consents to the care and treatment now and in the future of the patient listed below.

Please Print Patient's Name _____

Signature of Patient, Parent, or Legal Guardian

Relationship



ALLERGY AND ASTHMA ASSOCIATES
OF NORTHERN CALIFORNIA

Notice of Privacy Practices
Effective Date: April 1, 2003

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Official at (408) 243-2700 extension 221.

A. HOW THIS MEDICAL PRACTICE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment-** We use medical information about you to provide your medical care. We may share your medical information with other health care providers who will provide services which we do not provide. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. **Payment-** We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. **Health Care Operations-** We may use and disclose medical information about you to operate this medical practice. For example, to review and improve the quality of care we provide to obtain authorizations or referrals, for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management, and with our "business associates", such as our billing service, which we have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information.
4. **Appointment Reminders-** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
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. **Notification and communication with family-** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing-** We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.
8. **Required by law-** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
9. **Public health-** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. **Health oversight activities-** We may disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
11. **Judicial and administrative proceedings-** We may disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information in response to a subpoena.

12. **Law enforcement-** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
13. **Coroners-** We may disclose your health information to coroners in connection with their investigations of deaths.
14. **Public safety-** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
15. **Specialized government functions-** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
16. **Worker's compensation-** We may disclose your health information as necessary to comply with worker's compensation laws. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
17. **Change of Ownership-** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
18. **Research-** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. YOUR HEALTH INFORMATION RIGHTS

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision.
4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. **You have a right to a paper copy of this Notice of Privacy Practices.** If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area.

E. COMPLAINTS

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. You will not be penalized for filing a complaint

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
 Office of Civil Rights
 Hubert H. Humphrey Bldg.
 200 Independence Avenue, S.W.
 Room 509F HHH Building
 Washington, DC 20201