ARIZONA ALLERGY ASSOCIATES

Practice limited to Allergy, Asthma, and Immunology
Adults and Pediatrics

Patient Registration Form

PATIENT INFORMATION:

Name of Patient: _____ Date of Birth: _____ Sex: □Male □Female

Marital Status: □Single □Married □Widowed □Divorced □Separated Referring Physician: _____

Primary Care Physician: _____Other Specialists: _____

Patient's Address:_____,Apt #_____, City_____, State____, ZIP Code _____

Home Phone #:_____ Cell Phone #: _____ Work Phone #: _____

Where is the Patient Employed and Work Address:_____

Emergency Contact: Name -_____Phone#_____

Spouse Name: _____Phone #_____

Who is responsible for this account? _____ Phone #_____

Is the Patient attending school? □Yes □No If Yes, which school: _____

Email Address: _____

PARENTAL INFORMATION: Please complete the following if patient is a Minor OR on a Parent's Insurance Plan:

Father's Name: _____ Father's Date of Birth: _____ Father's SSN: _____

Father's Employer: _____ Contact Phone #: _____

Mother's Name: _____ Mother's Date of Birth: _____Mother's SSN: _____

Mother's Employer: _____ Contact Phone #:_____

What is the Parent's Marital Status: □Single □Married □Widowed □Divorced □Separated

May we contact the other parent? □Yes □No

HEALTH INSURANCE:

Primary Insurance: _____ If AHCCCS, which plan? _____

What is the Insurance ID#: _____ What is the Insurance Medical Group#: _____

What is the Policy Holder's Name: _____What is the Policy Holder's DOB: _____

What is the Patient's Relationship to the Policy Holder: _____

Secondary Insurance: _____ If AHCCCS, which plan? _____

What is the Insurance ID#: _____What is the Insurance Medical Group#:_____

What is the Policy Holder's Name: _____What is the Policy Holder's DOB:_____

What is the Patient's Relationship to the Policy Holder: _____

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ELECTRONIC STATEMENTS: I consent to receiving electronic statements. □ Yes □ No

AUTHORIZATION TO LEAVE DETAILED MESSAGES:

May we leave detailed messages on your answering machine, voicemail system, or with another member of your family? Our current privacy practices allow us to call you with a courtesy reminder regarding any upcoming appointments. If we may leave messages with another member of your family (including your spouse), please specify in the space below.

□Yes, I consent for detailed messages to be left on my answering machine or voicemail system or with another member of my family.

Messages may be left with the following: **(Please include relationship to patient)**

_____ Phone#: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

□No, I DO NOT consent for detailed messages (only general messages) to be left on my answering machine or voicemail system or with another member of my family.

□I wish to RESCIND or STOP the above authorizations.

AUTHORIZATION TO OBTAIN MEDICATION HISTORY:

I hereby authorize Arizona Allergy Associates to obtain Medication History related to the patient from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment and in order to **submit and receive Electronic Prescriptions.**

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Arizona Allergy Associates may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

□Yes, I authorize Arizona Allergy Associates to obtain Medication History and to send and receive Electronic Prescriptions.

□No, I do not authorize Arizona Allergy Associates to obtain Medication History and to send and receive Electronic Prescriptions.

Patient/Legal Guardian Signature	Name of Patient	Relationship to Patient
Legal Guardian Printed Name(if applicable)	Date of Birth of Patient	Date form signed
AAA Witness Signature	Date	AAA Witness Printed

FINANCIAL POLICY

PATIENT INFORMATION: Thank you for choosing Arizona Allergy Associates (AAA) as your allergy and immunology health care provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy and Cancellation/No Show Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

We request ALL patients complete our Patient Information Form prior to seeing the provider and **annually thereafter**. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.) It is the patient responsibility to provide the office with current insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. We may occasionally request a copy at a later date to update your records so please have your insurance card every time you come to the office. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the office.

FINANCIAL INFORMATION: Your insurance is a contract between you and your insurance company. We are contracted with most insurance plans and will file claims and process these as required by these contracts. We will file a claim for you as a courtesy if we are not contracted with your insurance carrier/plan. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary to you and/or your insurance company. You are ultimately responsible for the timely payment of your account. If your insurance company does not pay us within a reasonable time, we may look to you for payment for services rendered. All plans are not the same and they do not cover the same services. In the event your insurance company determines a service provided was "not covered", you will be responsible for the complete charge. This office is not responsible for disputing insurance company decisions regarding coverage. We expect that you know your insurance benefits, including but not limited to, deductible, co-payment amounts, laboratory services, radiology facilities and hospitals associated with your plan. We will provide a cost estimate to you upon request. It is your responsibility to notify this office when your insurance company or plan benefits change. Any charges that remain uncovered because of incorrect information provided to us by you or your representative will become your responsibility. If you are covered by an insurance plan that AAA is not contracted with or participates with, or you have no insurance coverage, our charge for your care or the care of your dependents will be due at the time of service. Payment is due upon receipt of a statement from our office.

If you need an insurance referral from a primary care physician, make sure the referral is in our office BEFORE YOUR SCHEDULED APPOINTMENT. **Referral Fax: 480-839-1874**. You may call our office to see if you need a referral form.

CO-PAYS ARE DUE AT THE TIME OF SERVICE PRIOR TO SEEING THE PROVIDER. There will be a $25.00 charge added if we have to bill for the co-payment. **We do not accept Cash, American Express or Discover**. Payment is accepted with Visa, MasterCard, personal check, Cashier's check, or Money Order with valid ID only. Please take time to read our full Financial Policy and Waiver; Cancellation/No Show Policy and Patient Information Form – these are very important documents and require your understanding and signature PRIOR to you being seen. **Note**: **A fee of 40% will be added to unpaid balances that require collection and/or legal services.**

CANCELLATION/NO SHOW POLICY: In order to ensure that the quality of patient care is maintained and all patients can be accommodated, it is important that you notify our office of your intentions to cancel or change your appointment at least twenty-four hours (24) prior to your scheduled appointment by calling **(480) 897-6992**. If you have an appointment scheduled on a Monday you may leave a message over the weekend on the voicemail or use the patient portal at www.azallergy.com to notify us. If no call is received within this time period you will be considered a "no show" and a charge will be assessed at $75.00. **Note**: This assessment will not be charged to your insurance company and you will be solely responsible for payment. Please take the time and consideration needed to provide the proper

notification of your intent to cancel your visit with your provider. We understand that there are emergencies and/or obligations that will require you to miss a scheduled appointment without notification and we will take these instances into account, however, we strongly encourage you to inform us as soon as possible so that we can accommodate another patient in that visit slot. If you have three or more missed appointments, we reserve the right to discharge you from the practice. If discharged, you will be notified in writing via Certified Mail.

We reserve the right to charge for copies of your patient records. You may request a copy of records annually at no cost. There is no cost to copy records for other physician offices. A charge of $25 may be assessed for any forms that need to be filled out by our providers. This will be collected prior to the paperwork being completed. If forms are faxed to the practice payment will be required by credit card prior to paperwork being completed.

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I understand, with this signed consent, AAA may use and disclose my/my child's health information to carry out treatment, payment and healthcare operations. I understand as part of healthcare, AAA originates and maintains paper and/or electronic records describing my or my child's health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I have the right to review the Notice of Privacy Practices prior to signing this consent and I have been provided with a copy to read. AAA reserves the right to revise its Notice at any time and a copy can be obtained by any patient/parent by sending a request to our offices.

I have the right to request that AAA restrict how it uses or discloses my/my child's healthcare information. However, the practice is not required to agree to the restrictions requested. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, due to the restrictions on disclosure of healthcare information and its effect on the ability to perform diagnosis and treatment, AAA will be unable to provide treatment for me/my child(ren).

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BENEFIT ASSIGNMENT

(1) I hereby assign my insurance benefits to be paid directly to the physicians or, if my current policy prohibits direct payment to the doctor, I instruct and direct my insurance company to make the check payable to Arizona Allergy Associates and me.

(2) I authorize the physician to deposit checks received on the patient's account when made out to the patient.

(3) I authorize the physician to release any information required to process claims or required in the course of my exam and treatment.

(4) I hereby agree to pay my account as services are provided. If for any reason a balance is owed on my account, I agree to pay promptly upon receipt of the monthly statement.

By signing this document, I state that all information given is accurate and current. If my insurance denies payment, I understand that I am financially responsible for charges.

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Notice of Privacy Practices

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Arizona Allergy Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting. We may also send you information describing other health-related products and services that we believe may interest you.

Fundraising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.
☐ Please do not use my information for fund-raising purposes.

Marketing. Unless you request us not to, there are some marketing activities for which we may use your name and address, to provide you with information about services available at our practice. If you'd rather not receive marketing communication from our practice, please check off the following box:
☐ Please do not use my information for marketing purposes

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Arizona Allergy Associates' Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting a Front Office Coordinator or the HIPAA Privacy and Security Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

HIPAA Privacy and Security Officer
Arizona Allergy Associates
705 South Dobson Road
Chandler, AZ 85224

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is:

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HIPAA Privacy and Security Officer
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Effective Date

This notice is effective on or after June 1, 2017

Arizona Allergy Associates reserves the right to modify the privacy practices outlined in the notice.

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