ARIZONA ALLERGY ASSOCIATES

NEITHER THE COMPLETION OF THESE FORMS NOR THE ACCEPTANCE OF OUTSIDE MEDICAL RECORDS CONSTITUTES THE ESTABLISHMENT OF A DOCTOR/PATIENT RELATIONSHIP. THIS IS ESTABLISHED AT YOUR INITIAL VISIT.

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: _____

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)

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

If you would like to delegate another individual to have unrestricted access to your medical record and the information contained therein please provide the information in the space provided below. This permission is also revocable with written request from you at any time.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____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.

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, credit card on file, 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.

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.

ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE PRIOR TO SEEING THE PROVIDER. This arrangement is part of your contract with your insurance company. There will be a $25.00 charge added if we have to bill for the co-payment. Patients will be requested to maintain a valid credit card on file for any balances that are not paid by insurance. You will be requested to sign a credit card authorization form, which permits us to charge your credit card in the event you have any charges that are not covered by your insurance, charges that fall under the co-payment or deductible portion of your plan, or administrative fees that are assessed by AAA such as no-show fees. If you do not place a credit card on file or fail to sign the credit card authorization form, we will not be able to see you for your scheduled appointment. We are happy to reschedule your appointment for another time once you fulfill these requirements. **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; Credit Card Authorization Form; 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.

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.

Signature	Name of Patient	Relationship to Patient
Printed Name	Date of Birth of Patient	Date form signed
AAA Witness Signature	Date	Witness Printed

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).

Signature Patient Name Date Form Signed

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:

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

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.

Skin Testing

Any testing that may be required will be discussed with the provider at the time of your appointment. We may be able to do skin testing, if indicated, but our testing protocol requires that patients not take any antihistamines for five (5) days prior to skin testing. If you are taking antihistamines prescribed by your physician or if you have significant skin irritation or hives, please do not discontinue the antihistamines. Any skin testing that is required will be scheduled after you have seen a provider here.

The more common antihistamines are listed below. This is not a complete list of all antihistamines. Many over-the-counter medications and combination drugs contain antihistamines. If you are uncertain if the medication you are taking contains an antihistamine, please do not hesitate to call our office or check with your primary care physician or local pharmacist.

NAME BRAND ANTIHISTAMINES	
Advil PM	Pepcid (famotidine)
Alavert	Periactin
Alka Seltzer Plus Cold	Phenergan
Allegra	Tagamet (cimetidine)
Antivert	Tavist
Astelin Nasal Spray	Tussionex
Atarax	Tylenol Allergy
Benadryl	Tylenol Cold
Bromfed	Tylenol Flu
Claritin	Tylenol PM
Clarinex	Unisom
Deconamine	Vistaril
Dimetapp Cold & Allergy	Xyzal (levocetirizine)
Doxepin	Zantac (ranitidine)
Extendryl	ZQuil
Hycomine Compound	Zyrtec
Kronofed	OTC cough & cold medications
Meclizine	OTC sleep medications
Nyquil	Any medication with "sinus", "allergy" or "hist" in the name
Eye drops:	Patanol, Pataday, Pazeo

	Zaditor/Alaway
Nasal Spray:	Patanase, azelastine, astelin
GENERIC ANTIHISTAMINES	
acrivastine	diphenhydramine
azelastine	fexofenadine
brompheniramine	hydroxyzine
cetirizine	loratadine
chlorpheniramine	promethazine
cyproheptadine	pyrilamine
desloratadine	levocetirizine
Olapatadine eye drops	Ketotifen eye drops
Olopatadine nasal spray	

Signature | Name of Patient | Relationship to Patient

Printed Name | Date of Birth of Patient | Date form signed

AAA Witness Signature | Date | Witness Printed

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Patient Registration Form

Patient Name: _____ Patient Date of Birth: _____

Please list the Medical Provider who referred you to our office: _____

What is your chief complaint or primary reason for coming in today?

- ○ Nasal Allergies
- ○ Asthma/Trouble Breathing
- ○ Eczema
- ○ Rash
- ○ Post Nasal Drip/Drainage
- ○ Cough
- ○ Eye Allergies
- ○ Possible Food Allergies
- ○ Hives
- ○ Sinus Infection
- ○ Skin Swelling
- ○ Other: _____

PAST MEDICAL HISTORY:

Has the patient been diagnosed with one of the following conditions: Please check all that apply.

- ○ None
- ○ Eye Allergy
- ○ Eosinophilic Esophagitis
- ○ Seasonal Allergies
- ○ Contact Allergy (Latex/Jewelry/etc.)
- ○ Angioedema
- ○ Asthma
- ○ Chronic Sinus Infections
- ○ Eczema
- ○ Drug Allergy

Has the patient ever been formally diagnosed with an insect allergy that required Epinephrine and/or emergency medical services (911, ER visit, ambulance)? If so, which insect?

- ○ None
- ○ Wasp
- ○ Ant
- ○ Yellow Jacket/Hornet
- ○ Bee
- ○ Yes, but not identified

Which of the non-allergy conditions has the patient been diagnosed with: (Please check all that apply)

- ○ None
- ○ Acid Reflux
- ○ High Thyroid
- ○ Sleep Apnea
- ○ Lactose Intolerance
- ○ Anxiety
- ○ High Blood Pressure
- ○ Heart Disease
- ○ Celiac Disease
- ○ Depression
- ○ COPD
- ○ Lupus
- ○ Food Intolerance or Sensitivity
- ○ Low Thyroid
- ○ Emphysema
- ○ Rheumatoid Arthritis

Has the patient ever been allergy tested before? Circle one: YES NO

Has the patient ever been on allergy shots? Circle one: YES NO

Are the Patient's immunizations up to date?

- ○ Yes
- ○ No Immunizations
- ○ Incomplete
- ○ Delayed Schedule

Has the patient ever been hospitalized overnight for Pneumonia, RSV, Asthma, or Bronchitis? (Do not include ER and Urgent Care visits where patient was sent home same day.)

- ○ No ○ Pneumonia ○ Asthma ○ RSV ○ Bronchitis

Has the patient ever been admitted in a hospital ICU, NICU, or PICU? Please include approximate date and reason.

ICU, NICU, or PICU	Reason	Approximate Date

SURGICAL HISTORY:

Has the patient ever undergone any of the following procedures: (Please check all that apply)

- ○ None ○ Tonsillectomy ○ Adenoidectomy ○ Sinus Surgery ○ Tubes in Ears

Please list any other major surgeries the patient has undergone: (Please include Approximate Date)

- ○ NONE

Surgery:	Approximate Date:

FAMILY HISTORY: Does Patient's Mom, Dad, Brother, Sister, or Children have any of these conditions: Please check all that apply and **please note next to each condition which family member (e.g. Allergies – Mom)**

- ○ None
- ○ Eczema
- ○ Eosinophilic Esophagitis
- ○ Ulcerative Colitis
- ○ Allergies
- ○ Drug Allergy
- ○ Lupus
- ○ Angioedema
- ○ Asthma
- ○ Cancer
- ○ Rheumatoid Arthritis
- ○ Food Allergy
- ○ Thyroid Issues
- ○ Crohn's Disease

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Patient Registration Form

SOCIAL HISTORY: Does the patient currently use or consume any of the following? (Please check all that apply)

- ○ N/A
- ○ Alcohol
- ○ Drugs
- ○ Cigarettes
- ○ Packs per day _____
- ○ How long did you smoke? _____
- ○ Quit Date? _____

ENVIRONMENTAL HISTORY:

Does the patient have any of these pets living with them at home?

- ○ None
- ○ Dog
- ○ Cat
- ○ Horse
- ○ Other:_____

Do you have or use any of the following items: (Please check all that apply)

- ○ HEPA Filter
- ○ Dust Mite covers for pillow or blanket
- ○ Carpet in most of the home
- ○ Air Ionizer
- ○ Feather Comforter
- ○ No Carpet/Very Little Carpet
- ○ Humidifier
- ○ Feather Pillows
- ○ Vaporizer
- ○ Carpet in Bedrooms

FOOD ALLERGIES: Has the patient ever been officially diagnosed with one of the following food allergies and prescribed Epinephrine?

- ○ None
- ○ Peanut
- ○ Wheat
- ○ Milk
- ○ Tree Nuts
- ○ Shellfish
- ○ Egg
- ○ Soy
- ○ Fish

CURRENT MEDICATIONS: Please list all current medications: (Please include all allergy and non-allergy medications)

REVIEW OF SYMPTOMS (ROS): Is the patient experiencing any of these symptoms? Please check all that apply.

- o Fever
- o Weight Gain/Loss
- o Eye Pain
- o Shortness of Breath
- o Sputum
- o Dark Stool
- o Painful Urination
- o Morning Stiffness
- o Easy Bruising
- o Numbness
- o Too Hot/Cold
- o Frequent Throat Clearing
- o Cold Sores
- o Sniffling
- o Stuffy Nose
- o Nose Surgery
- o Broken Nose
- o Headaches
- o Blurred Vision
- o Chest Pain
- o Wheezing
- o Abdominal Pain
- o Nausea/Vomiting
- o Urinary Frequency
- o Cramps
- o Rashes
- o Dizzy Spells
- o Tired/Sluggish
- o Frequent Tonsillitis
- o Sneezing
- o Watery Mucus
- o Sinus Infections
- o Polyps
- o Loss of Smell
- o Chills
- o Double Vision
- o Palpitations
- o Frequent Cough
- o Indigestion
- o Urine Retention
- o Joint Pain
- o Easy Bleeding
- o Tremors
- o Excessive Thirst
- o Sore Throat
- o Itchy Throat/Hoarseness
- o Itching
- o Nose Bleed
- o Snoring
- o Post-Nasal Drip
- o None

MEDICATION INFORMATION: What medications has the patient used? (Please check all that apply)

- o Zyrtec/Cetirizine
- o Hydroxyzine
- o Xyzal/Levocetirizine
- o Rhinocort
- o Veramyst
- o Atrovent/Ipratopium Bromide Nasal Spray
- o Albuterol via nebulizer
- o Advair
- o Dulera
- o Zaditor/Ketotifen
- o Pataday
- o Claritin/Loratadine
- o Benadryl
- o Flonase/Fluticasone
- o Nasonex
- o Astelin/Azelastine
- o ProAir
- o Budesonide/Pulmicort
- o Qvar
- o Breo
- o Pazeo
- o Other: _____
- o Allegra/Fexofenadine
- o Singulair/Montelukast
- o Nasacort
- o Qnasl
- o Dymista
- o Ventolin
- o Flovent
- o Symbicort
- o Arnuity
- o Visine Allergy

Has the patient taken any antihistamines or medications containing antihistamines within five (5) days of the appointment? Including, but not limited to the following medications: Zyrtec, Claritin, Allegra, Xyzal, Alavert, Unisom, Zantac, Pepcid, Meclizine, Tylenol PM, Cold and Sinus Medicine. Circle one: YES NO