ALLERGYCENTER OFCONNECTICUT

PATIENT INFORMATION

NAME (Please print): _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone (____)_____ Cell phone (____)_____ Work phone (____)_____

Gender: ❑ Female ❑ Male Preferred Language: _____ Ethnicity (optional): _____

Email: _____

Pharmacy: _____ Phone: (____)_____

In case of emergency who should be notified? _____ Relationship: _____

Home phone (____)_____ Cell phone (____)_____ Work phone (____)_____

❑ Referred by a Doctor _____

❑ Referred by a Patient _____

❑ Insurance company or Website _____

Primary Physician: _____

Address: _____ Phone: (____)_____

ACCOUNT INFORMATION

Adult responsible for payment (PRIMARY INSURANCE HOLDER) (Please print):

_____

Relationship to patient: _____ DOB: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Home phone (____)_____ Cell phone (____)_____ Work phone (____)_____

Primary insurance company: _____

Secondary insurance company: _____

MEDICAL HISTORY

REASON FOR VISIT: _____

CHRONIC MEDICAL CONDITIONS, HOSPITALIZATIONS, SURGERIES:_____

_____

CURRENT MEDICATIONS: _____

_____

_____

MEDICATION / FOOD ALLERGIES: _____

_____

_____

4 Corporate Dr, Suite 295, Shelton, CT - phone: 203-374-6103, fax: 203-374-1663
761 Main Ave, Suite 105, Norwalk, CT - phone: 203-870-8731, fax: 203-803-2730
www.allergyct.com

ALLERGYCENTER OFCONNECTICUT

PREVIOUSLY TRIED MEDICATIONS - ALLERGY ONLY

	MEDICATION	DATES	BENEFIT
1			□ helpful □ not helpful
2			□ helpful □ not helpful
3			□ helpful □ not helpful
4			□ helpful □ not helpful
5			□ helpful □ not helpful
6			□ helpful □ not helpful
7			□ helpful □ not helpful
8			□ helpful □ not helpful
9			□ helpful □ not helpful
10			□ helpful □ not helpful

Your **insurance** will determine which medications are covered and their cost. If there is a medical necessity, then an **appeal or prior authorization** will be submitted on your behalf. Please allow 48 hours for processing.

_____

Print Name of Patient (or Parent/Guardian for minor) - Signature - Date

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ALLERGYCENTER OFCONNECTICUT

AGREEMENT AND CONSENT FOR MEDICAL SERVICES

1. **Agreement and consent.** I hereby authorize medical services to be provided by the physicians and medical staff of the Allergy Center of Connecticut, P.C. until revoked by me in writing.
2. **Release of information.** I hereby authorize the Allergy Center of Connecticut, P.C. and all physicians involved with my care to release information from my medical records as may be required to any person, corporation or agency which is legally responsible or which the Allergy Center of Connecticut, P.C. has good cause to believe is legally responsible, for processing and/or paying all or any part of the Allergy Center of Connecticut, P.C.'s charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize the Allergy Center of Connecticut, P.C. or any physician involved with my care to release information to any physician or health care facility to which I may be transferred for further medical care.
3. **Assignment of Insurance Benefits.** I authorize that payment be made directly to the Allergy Center of Connecticut, P.C. for any insurance benefits payable for those services provided by the Allergy Center of Connecticut, P.C. This authorization expressly includes any benefits that are to be provided by Medicare and any other public or private insurance plans. This order will remain in effect until revoked by be in writing.
4. **Acknowledgment of Financial Responsibility:** I acknowledge that I have received a copy of the Allergy Center of Connecticut, P.C. Financial Policy. I have read and thoroughly understand the financial policy stated above, and I agree to accept financial responsibility as described. I hereby agree to pay the Allergy Center of Connecticut, P.C. the charges for all medical services rendered. If I am agreeing and signing on behalf of a minor patient, I affirm that I have the legal right to consent and agree on behalf of that minor.
5. **Acknowledgment of Notice of Privacy for Protected Health Information**. I acknowledge that I have received a copy of the Allergy Center of Connecticut, P.C. Notice of Privacy.

Privacy policy - attached.

Financial policy - attached.

_____

Print Name of Patient (or Parent/Guardian for minor) - Signature - Date

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E-PRESCRIBING CONSENT

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include: **Formulary and benefit transactions (**information about which drugs are covered by the drug benefit plan), **Medication history transactions (**information about medications the patient is already taking to minimize the number of adverse drug events), **Fill status notification** (electronic notices from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.)

By signing this consent form you are agreeing that Allergy Center of Connecticut can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Allergy Center of Connecticut to participate in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____

Print Name of Patient (or Parent/Guardian for minor) - Signature - Date

EMAIL CONSENT

Information stored on our computers is encrypted. However, most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet.

In addition, once the email is received by you, someone may be able to access your email account and read it. Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

I understand the risks of unencrypted email and do hereby give permission to the Austin Med Clinic to send me personal health information via unencrypted email

_____

Print Name of Patient (or Parent/Guardian for minor) - Signature - Date

ALLERGYCENTER OFCONNECTICUT

PRIVACY POLICIES

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.

This Notice describes privacy practices of this facility, including: any health care professional authorized to enter information into your health/medical records; any volunteer group we allow to help while you are receiving care.

I. Our Duty to Safeguard Your Protected Health Information: Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for your health care is considered "Protected Health Information" ("PHI"). We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. We are required by law to make sure that your PHI is kept private and to give you this Notice about our legal duties and privacy practices, that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

We must follow the privacy practices described in this Notice, though **we reserve the right to change our privacy practices and the terms of this Notice at any time.** If we change this Notice, we will post a new Notice in patient registration and/or patient reception. The Notice will contain the effective date on the first page, top right-hand corner. You may request a copy of the new Notice from the staff *(and it will also be posted on our website at www.allergyct.com.)* We will also make available a copy of the Notice in effect each time you visit.

II. How We May Use and Disclose Your Protected Health Information: We use and disclose PHI for a variety of reasons. For certain uses/disclosures, we must get your written authorization. However, the law provides that we may make some uses/disclosures without your authorization. The following section offers more description and examples of our potential uses/disclosures of your PHI.

• **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations**. Generally, we may use/disclose your PHI:

For treatment: We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team, pharmacy staff, or with a specialist to whom you have been referred.

To obtain payment: We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicare/Medicaid, a private insurer or group health plan to get paid for services that we delivered to you. Release of your PHI to the state Medicaid agency might also be necessary to determine your eligibility for publicly funded services.

For health care operations: We may use/disclose your PHI in the course of our operations. For example, we may use your PHI or your answers to a patient satisfaction survey in evaluating the quality of services provided by our staff, or disclose your PHI to our auditors or attorneys for audit or legal purposes.

Appointment reminders: Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home. We may also call your home and leave a message on your answering machine or voicemail. (See Section III about confidential communication.)

Treatment Alternatives: We may contact you about possible treatment options or alternatives, or other health-related benefits or services that may interest you.

• **Uses and Disclosures Requiring Authorization:** For uses and disclosures other than treatment, payment and operations purposes, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. You may revoke an authorization, in writing, any time to stop future uses/disclosures. If you revoke your authorization, we will stop using/disclosing your PHI for purposes or reasons covered by your written authorization. You need to understand that we are unable to take back disclosures we have already made with your permission and that we are required to keep our records of the care we provided to you. (See Section VI for instructions for revoking an authorization.) We cannot refuse to treat you if you refuse to sign an authorization to release PHI, unless services provided are solely to create health records for a third party, such as a physical and drug testing for an employer or insurance company; or if treatment provided is research-related and authorization is required for the use of health information for research purposes.

• **Uses and Disclosures Not Requiring Authorization:** The law provides that we may use/disclose your PHI without your authorization in the following circumstances:

When required by law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, for FDA-regulated products or activities, or in response to a court order. We must also

disclose PHI to authorities that monitor compliance with these privacy requirements.

For public health activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority, such as reports of tuberculosis cases or births and deaths.

Relating to decedents: We may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

For research purposes: In certain circumstances, that have been approved by an Institutional Review Board, we may disclose PHI in order to assist medical research, such as comparing the health and recovery of all patients who received one medicine to those who received another. We will almost always ask you for your specific permission if the researcher will have access to your name, address and other PHI, or will be involved in your case.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement officials in circumstances such as: in response to a court order; to identify a suspect, witness or missing person; about crime victims; about a death that we may suspect if the result of criminal conduct; or criminal conduct at the health care facility.

For specific government functions: We may disclose PHI of military personnel and veterans in certain situations; to correctional facilities in certain situations; and for national security and intelligence reasons, such as protection of the President.

Workers' Compensation: We may disclose your PHI to your employer for Workers' Compensation or similar programs that provide benefits for work-related illness or injury.

Inmates: An inmate does not have rights listed in this Notice of Privacy Practices. The rights listed in this notice will not apply to inmates of a correctional institution.

• **Uses and Disclosures Requiring You to Have an Opportunity to Object:** In the following situations, we may disclose your PHI if we inform you about the disclosure in advance and you have the opportunity to agree to or prohibit or restrict the disclosure. However, if there is an emergency situation and you cannot be given the opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and the disclosure is determined to be in your best interests. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

To families, friends or others involved in your care: We may share with these people information directly related to your family's, friend's or other person's involvement in your care or payment for your care. We may also share PHI with these people to notify them about your location, general condition or death.

Disaster relief: We may release your PHI to a public or private relief agency for purposes of coordinating notifying your family and friends
of your location, condition or death in the event of a disaster.

III. Your Rights Regarding Your Protected Health Information: You have the following rights relating to your protected health information:

To request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI. You must make your request in writing. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. If agreed upon, these restrictions will only apply to this health care facility. You understand that we are not able to take back disclosures already made. We cannot agree to limit uses/disclosures that are required by law.

To request confidential communication: You have the right to ask that we send you information at an alternative address or by an alternative means, such as contacting you only at work. You must make your request in writing. We must agree to your request as long as it is reasonably easy for us to do so.

To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed. You have a right to choose what portions of your information you want copied and to have information on the cost of copying in advance.

To request amendment to your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. Written requests must include a reason that supports your request. We will respond within 60 days of receiving your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if we determine that the PHI is: (1) correct and complete; (2) not created

by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial reviewed, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI. Any laboratory records subject to the Clinical Laboratory Act of 1988 (CLIA) are exceptions to this rule.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure for which you gave your written authorization. (This is called an accounting of disclosures.) Your request can relate to disclosures going as far back as six (6) years. Your request must be in writing. We will respond to your written request for such a list within 60 days of receiving it. There will be no charge for the first list requested each year. There may be a charge for subsequent requests.

To receive a paper copy of this Notice: You have a right to receive a paper copy of this Notice and/or an electronic copy by email upon request. To obtain a copy of this Notice, contact this facility's Privacy Contact.

IV. How to Complain about our Privacy Practices: If you think we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI, you may file a complaint with the facility's Privacy Contact. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized if you file a complaint.

V. Contact Person for Information or to Submit a Complaint: If you have questions about this notice or any complaints about our privacy practices, please contact this facility's Privacy Contact.

VI. Instructions for Revoking an Authorization: You may revoke an authorization to use or disclose your PHI, in writing, except: 1) to the extent that action has been taken in reliance on the authorization, or 2) if the authorization was obtained as a condition of obtaining insurance coverage and law provides the insurer with the right to contest a claim under the policy. Your written revocation must include the date of the authorization, the name of the person or organization authorized to receive the PHI, your signature and the date you signed the revocation.

VII. **Effective Date:** This Notice was effective 8/1/09

ALLERGYCENTER OFCONNECTICUT

FINANCIAL POLICIES

Thank you for choosing us as your health care provider. We appreciate your confidence and trust. Payment for your care is considered part of your treatment program. If you have any questions regarding our financial policy, please call our office manager during business office hours.

All patients must complete our patient and insurance information sheets prior to seeing the physician. If these forms are not completed, you may be asked to reschedule your appointment.

If you do not have insurance, we expect payment in full at the time of service.

We are happy to file your insurance claim directly with your insurance company. Our insurance claims are computerized to insure proper filing. We will prepare and file insurance claims for the services you receive. However, please keep in mind that it is your insurance contract, and we look to you for payment, not your insurance company. All balances are due within 30 days of the statement date.

We require all co-payments and deductibles to be made at the time of service, without exception. You are obligated and responsible to pay your portion.

Statement of Managed Care Responsibilities: In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care programs. While we are happy to provide this service, it is extremely difficult to keep track of all the individual requirements of each and every plan. Even within the same insurance company, the plans may differ depending on what type of contract your employer has negotiated. Therefore, if you do not inform us of any pre- authorization requirements in your contract, and we subsequently treat you without the necessary authorization, we will have no choice but to bill you directly for the charges.

Lost Prescriptions & Refills: Prescription refill requests are handled during office hours by phone. Refill requests can take up to 48 hours to process.

Medicare: Our office is enrolled in the Medicare program, which means we have a signed contract with Medicare to accept assignment of Medicare benefits for our services. We will complete and submit your Medicare insurance form for you. Medicare will pay its share of the bill directly to us. You will be responsible for annual deductibles and co-payments.

Appointments and Cancellations: Promptness is appreciated for all appointments. All patients including those receiving allergy shots are required to check in. We require 24 hours notice if you need to cancel your appointment. (We have voice mail available after hours.) This will allow us time to offer your appointment to another patient. In order for our providers to deliver quality care, you will need to arrive at your scheduled time. Therefore, if you arrive fifteen or more minutes late for your appointment, you may be asked to reschedule. Failure to provide advance notice for canceling an appointment will have the following charge schedule applied. First occurrence: missed appointment warning letter; Second occurrence: full scheduled service charge. If three appointments are missed with no advance notice, our professional relationship with you will be terminated and you will be asked to seek treatment from another health care provider. In the event of severe weather, please phone the office for delay or closing
information.

Medical Records Copying & Form Completion: Requests for copies of patient medical records will be subject to a fee as authorized by Connecticut Law. If records are to be mailed, there will be an additional postage charge.

Treatment of Minors: The parent or legal guardian who brings a minor to the office for treatment shall be responsible for all medical bills incurred at that time.