ALLERGY CENTER OF CONNECTICUT

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: ____

____

CURRENT MEDICATIONS: ____

____

____

MEDICATION / FOOD ALLERGIES: ____

____

____

ALLERGY CENTER OF CONNECTICUT

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.

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

ALLERGY CENTER OF CONNECTICUT

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.

6. **For minors.** I acknowledge that I am the parent or legal guardian with full authority to make medical decisions.

Privacy policy - attached.

Financial policy - attached.

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

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

ALLERGY CENTER OF CONNECTICUT

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.

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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 Allergy Center of Connecticut to send me personal health information via unencrypted email

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