ALLERGY CENTER OF CONNECTICUT

NEW PATIENT INTAKE FORM

PATIENT INFORMATION:

Name: ____ Date of birth: ________________

Address: _______________________________ City: ____________ State: _____ Zip: _________

Home phone: _______________ Cell phone: _______________ Work phone: ________________

Gender: ❑ Female ❑ Male Marital status: ❑ Married ❑ Single ❑ Divorced ❑ Other

Email: ____

Employment status: ❑ FT ❑ PT ❑ Not employed ❑ Student

Race: ❑ American Indian ❑ Asian ❑ Black or African American ❑ White or Caucasian ❑ Other

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Other

Preferred language: ______________

EMERGENCY CONTACT

Name: ____ Relationship to patient: ______________

Phone: ____________________________ (❑ Mobile ❑ Home ❑ Work)

PRIMARY CARE PHYSICIAN

Name: ____ Group: ____________________

Address: ____ Phone: ____________________

REFERRING PHYSICIAN

Name: ____ Group: ____________________

Address: ____ Phone: ____________________

PHARMACY INFORMATION

Name: ____

Address: ____ Phone: ____________________

INSURANCE INFORMATION

Insurance carrier (primary card holder)

Relationship to patient: ______________

Name: ____

Date of birth: ______________ Phone: ______________

Insurance company name: ____

Insurance member ID#: ____

GUARANTOR - Adult responsible for payment

Name: ____ Relationship to patient: ______________

Address: ________________________________ City: _____________ State: _____ Zip: _________

Home phone: ________________ Cell phone: ________________ Work phone: ________________

ALLERGY CENTER OF CONNECTICUT

OFFICE POLICIES (7.20.22)

Thank you for choosing us as your health care provider. We appreciate your confidence and trust.

1. **Consent for medical services.** I authorize medical services to be provided by the physicians and medical staff of the Allergy Center of Connecticut (ACC). For Minors, I acknowledge that I am the parent or legal guardian with full authority to make medical decisions.

2. **Financial.** I hereby agree to pay the ACC charges for all medical services rendered. Additionally, I authorize that insurance payments be made directly to the ACC for any insurance benefits payable for those services provided.

3. **Insurance.** All patients must provide insurance information prior to being seen. If you do not have insurance, payment is due in full at the time of service. All co-payments to be made at the time of service.

4. **Billing**. Claims and billing are processed by CPa Medical Billing (203-646-6746).

5. **Appointments, cancellations and no-shows.** Promptness is appreciated for all appointments. There is a no-show fee of $50 for appointments not cancelled or rescheduled with at least 24 hours notice. If you are more than 15 minutes late for an appointment, this is considered a no-show. If three appointments are missed you will be dismissed from the practice.

6. **Medical Records.** Requests for 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.

7. **School/camp/work forms.** As courtesy, we may complete one set of forms per patient per year. Our office requires 3 – 5 business days for forms to be completed from October through April. During heavy form season (May – September) the turnaround time is 7 – 10 business days.

8. **Prior authorization.** As a courtesy, we may complete prior authorization or other insurance forms on your behalf. Our office requires 3 – 5 business days for completion.

9. **E-prescriptions**. I authorize e-prescription transactions, including sending prescriptions, sending and receiving refill requests, access to formulary information and medication history.

10. **Patient communication.** We recommend that all patients sign up for and communicate messages and requests through the MyChart patient portal. Most popular email services 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. If you send us or request an email, you understand the risks of unencrypted email and do hereby give permission to the ACC to send me personal health information.

11. **Privacy**.

    1. 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 are required by law to make sure that your PHI is kept private.

    2. 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:

        a. For treatment: We may disclose your PHI to doctors, nurses, pharmacy staff and other health care personnel who are involved in providing your health care.

   b. To obtain payment: We may use/disclose your PHI in order to bill and collect payment for your health care services.

   c. 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.

   d. 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.

3. You may revoke an authorization, in writing, any time to stop future uses/disclosures. 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.

4. You have the following rights relating to your protected health information:

   1. 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.

   2. Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI.

   3. 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. 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.

12. **Shared medical record.** To better provide for your care and enhance your patient experience, we seek to coordinate and integrate our care delivery through our electronic medical record (EMR) which is paperless. We share access to the EMR across the Hartford Health Care (HHC) Medical Group and some other HHC affiliated practices. Our current EMR does not functionally allow us to limit access to your record by blocking it from HHC Medical Group staff and related practices. By signing this authorization form, you understand and agree that you are allowing disclosure of and access to all your health information, including information relating to alcohol and substance abuse/use, mental or behavioral health and HIV/AIDS. If health information about you includes any of these types of information, you specifically authorize the release of such information to, and access to such information by the authorized health care providers and professionals listed at wwa.hartfordhealthcaremedicalgroup.org/access. You may revoke this authorization at any time except to the extent it has already been relied upon. Unless earlier revoked this consent will expire if and when HHC Medical Group's EMR no longer exists. Since we do not use a paper system for documenting the care of patients, we can only use our EMR. We hope that you will find the EMR system facilitates your care. If you don't want your medical information stored in our EMR we unfortunately cannot care for you in this practice.

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

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761 Main Ave, Suite 105, Norwalk, CT - phone: 203-870-8731
www: allergyct.com / fax: 203-374-1663