ALLERGY AND ASTHMA ASSOCIATES
OF NORTHERN CALIFORNIA
A MEDICAL CORPORATION

Patient Information Form

Patient Name______________________________

Address______________________________

City ______________ State ______ Zip ______

Phone#: Home ____________________

Cell ____________________

Work ______________ Ext______

Date of Birth ______________ Gender______

Employer______________________________

Primary Care/Referring Physician

Physician's Name ____________________

Phone # ____________________

How did you hear about our office? ______________

Family Members Seen Here? ______________

____

Person Responsible for Bill (complete in full)

☐ Self ☐ Spouse ☐ Guardian ☐ Parent ☐ Other

Name ______________________________

Address______________________________

City ______________ State ______ Zip ______

Phone#: Home ____________________

Cell ____________________

Work ______________ Ext______

Date of Birth ____________________

Employer______________________________

Authorization for Payment/Release of Medical Records

I authorize release of medical records and payment of my benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

Signature ____________________

Date ____________________

Insurance Information

My Plan is a: ☐ PPO ☐ HMO ☐ POS (Point of Service) ☐ Other

Primary Insurance Name ____________________

Name of Insured ____________________

D.O.B.____________________

Member ID ____________________

Group # ____________________

Patient's relationship to primary insured:

☐ self ☐ spouse ☐ child ☐ other

Secondary Insurance ____________________

Name of Insured ____________________

D.O.B.____________________

Member ID ____________________

Group#____________________

Patient's relationship to primary insured:

☐ self ☐ spouse ☐ child ☐ other

Person to Contact in Case of Emergency

Name______________ Relationship______

Phone#: Home ____________________

Cell____________________

Work______________ Ext______

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Your signature on this form acknowledges your receipt of the Notice.

I acknowledge that I have received a copy of the Allergy & Asthma Associates of Northern California's Notice of Privacy Practices.

Signature ____________________ Date __________

ALLERGY AND ASTHMA ASSOCIATES
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FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. The following is a statement of our Financial Policy. We request that you read, agree to and sign below prior to treatment. All patients must complete our Registration Form, provide insurance information and present insurance card(s) and driver's license to be photocopied. If you do not have your insurance information at the time of your visit you will be personally responsible for the cost of services provided. Due to timely filing issues, we may be unable to submit your claim to your insurance carrier if we do not receive your insurance information within 10 business days following the date of your visit.

AAANC staff will submit your claim to your insurance carrier for payment. The balance after your insurance payment is received is your responsibility. All co-pays and deductibles are due at the time of service. Any balance on your account must be paid in full. Secondary insurance is billed as a courtesy to our patients**.** If your insurance company does not respond within 60 days, the balance will become your responsibility. All HMO plans require authorization from the assigned medical group. If an authorization is not obtained prior to your visit, charges are the responsibilities of the patient and are due at the time of the visit. Retroactive authorizations are not acceptable.

Services not covered by your insurance policy are your financial responsibility. Please note that testing may be subject to some plan limitations. Unless cancelled at least 24 hours in advance our policy is to charge $50.00 for missed appointments. Please help us serve you better by keeping your scheduled appointment.

The purpose of the Financial Policy is to clarify any questions you may have about your financial obligation to Allergy & Asthma Associates of Northern California. If the account becomes delinquent (not paid according to the above-stated policy), the doctor, his assigns, or lawful agents may pursue collection procedures. Thank you for understanding our Financial Policy. If you have questions about our policy, please ask before services are rendered.

I have read, understand and agree to the provisions of this Financial Policy. By signing below I agree and understand that the benefits quoted are not a guarantee of coverage and should the benefit coverage change I assume complete financial responsibility for my and/or my dependent(s) medical care. I understand that I will be responsible for all collection costs, including but not limited to court filing fees, service of process costs, interest and attorney fees should my and/or my dependent(s) account become delinquent.

_______________________________________ _______________________________________
Signature of Responsible Party Date Print name of Responsible Party

____
Signature of Authorized Representative of Allergy & Asthma Associates Date

<u>CONSENT TO TREATMENT :</u>
The undersigned hereby consents to the care and treatment now and in the future of the patient listed below.

Please Print Patient's Name ____

____
Signature of Patient, Parent, or Legal Guardian Relationship

ALLERGY AND ASTHMA ASSOCIATES
OF NORTHERN CALIFORNIA

Notice of Privacy Practices
Effective Date: April 1, 2015

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Official at (408) 243-2700 extension 221.

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 test and procedures will be available in your medical records 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 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.

Healthcare operations- Your health information may be used as necessary to support the day-to-day activities and management of Allergy and Asthma Associates of Northern California. For example, information on the service 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 may be used to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in sheet- We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and Communication with family- Your health information may be used to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

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

Required by law- As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public health- We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health oversight activities- Your health information may be used to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Judicial and administrative proceedings- Your health information may be disclosed in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information in response to a subpoena.

Law enforcement- We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners- We may disclose your health information to coroners in connection with their investigations of deaths.

Public safety- We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized government functions- We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Worker's compensation- We may disclose your health information as necessary to comply with worker's compensation laws. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Change of Ownership- In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Research- We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

Fundraising- Unless you requested 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 requested 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

WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION- Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time

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.

Allergy and Asthma Associates of Northern California 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 the 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.

Request to Inspect Protected Health Information

You may generally inspect or copy protected health information that we maintain. As permitted by federal regulations, we require that your request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Carminia Lopez, Privacy Official. Your request will be reviewed and will generally be approved unless there are any legal or medical reasons to deny 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:
Carminia Lopez, Privacy Official
Allergy and Asthma Associates of Northern California
4050 Moorpark Avenue
San Jose, CA 95117-1840

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

Carminia Lopez, Privacy Official
Allergy and Asthma Associates of Northern California
4050 Moorpark Avenue
San Jose, CA 95117-1840

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Department of Health and Human Services Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W. Room 509F HHH Building
Washington, DC 20201

This Notice is effective on or after 04/01/2015