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
OF NORTHERN CALIFORNIA
A MEDICAL CORPORATION

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

CONSENT TO TREATMENT:

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

Approved 01/03/07

Form 166WH
(Rev 01/07)

HIPAA Privacy Notice-Patient Acknowledgement

“Health Insurance Portability and Accountability Act”

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Federal Government has required that your medical records remain private, confidential, and unavailable to anyone without your expressed written consent. Our medical record of your care remains the physical property of Allergy and Asthma Associates of Northern California (AAANC). The state of California supports this law. Forms are used for you to authorize, in writing, the release of a copy of your specific medical records to another entity such as; physician, medical practice, or to an insurance company for treatment, payment, and operations of AAANC. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We use the 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. If you have any questions about this Notice, please contact our Privacy Official (Gracie Hernandez) at (408) 243-2700 ext. 246.

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, result 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.

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.

Health Care Operations- There remain certain operational activities, where, in the process of delivering medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals within this practice, without expressed written permission of each and every specific occurrence by you. Some examples include:

- Requesting Photo ID at your visit
- Taking and saving photograph of the patient for the chart to be used for identification and medical treatment
- Communicating with your pharmacy, insurance carrier, primary care provider, and other professionals involved in the patient’s healthcare (such as schools, day care or college health centers)
- Handling of the mail, newsletters, claims, bills, referrals
- Requesting that the office/reception staff call, text, or email you to schedule an appointment, acquire a referral, or to inform you about medications that may have be held for testing
- Medical staff leaving reasonable and limited messages informing you of potential treatment options such as labs or x-ray results
- Inform you of health-related benefits or services that may be of interest to you
- Verbal or written correspondence with insurance companies; yours and ours

- Discussing an opportunity to enroll you in ongoing Asthma Allergy Research; and/or continuation in research studies/clinical trials
- Routine inter-office communication between professional staff of this specialty practice to effectively manage your medical care

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.

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.

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. You may restrict disclosure of any part of your Private Medical Information from within this practice to any outside source or recipient, where not allowed by the law: Federal, State or by Court Order. Please not that any unsecured electronic communication initiated by the patient/family is done so at their own risk.

Your Rights under the Law:

You have the right to receive a notice about our privacy policy

The right to inspect your protected health information (PHI) with a provider in a private environment

The right to request a copy of PHI and to have returned to you in 30 days, unless notified in writing of 60-day return

The right to request a restriction on uses and disclosures of your protected health information

The right to request to receive confidential communications from the practice by alternative means or at an alternative location

The right to request an amendment of your protected health information

The right to request an accounting of disclosure of Protected Health Information (PHI)

The right to revoke or limit authorization

The right to be notified of a breach of your PHI

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 Gracie Hernandez, Privacy Official. Your request will be reviewed and will generally be approved unless there are any legal or medical reasons to deny request.

Please list by name and relation the person(s) that may receive messages or talk to us regarding patient's medical care.

__________________________________ _____________________________________

Name/relation Contact Number

__________________________________ _____________________________________

Name/relation Contact Number

__________________________________ _____________________________________

Name/relation Contact Number

ACKNOWLEDGEMENT

I, _____________________________________ (patient, responsible party), acknowledge that I have received a copy of Allergy and Asthma Associates of Northern California (the practice's) "HIPAA Privacy Notice-Patient Acknowledgment" document regarding protection of Personal Health Information (PHI).

Patient or Responsible Party's Signature ____________________________ Date ______________________

You may request at any time a detailed written policy of the Allergy and Asthma Associates of Northern California's "HIPAA Privacy Notice-Detailed" or access it at www.allergycare.com

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:
Gracie Hernandez, 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

Gracie Hernandez, 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 01/01/2020

TERMS AND CONDITIONS OF SERVICE: REGISTRATION, MEDICAL SERVICES, AND FINANCIAL AGREEMENT

1. **MEDICAL CONSENT:** I consent to medical treatments or procedures, medications, injections, taking of treatment related photographs, videotaping, and laboratory procedures, rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. To facilitate my care, I consent to evaluation and examination by a physician or other health team professionals who may be physically distant from me via telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies as determined by my providers.
2. **RELEASE OF MEDICAL INFORMATION:** The State of California Information Practices Act requires Allergy and Asthma Associates of Northern California (from here referred to as "AAANC") to provide the following information to individuals who supply information about themselves. As a patient of AAANC, I will be asked to submit certain personal information, such as my address and phone number, Social Security Number, insurance information, medical history, and treatment history. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under federal and state laws and regulations, AAANC is authorized to maintain this information. As required by AAANC, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. AAANC will obtain my written authorization to release information about my medical treatment, except in those circumstances when AAANC is permitted or required by law to release information (see AAANC's Notice of Privacy Practices for a description of the specific circumstances under which AAANC may release this information). For example, AAANC may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers.
3. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for all of my medical services. For instance, if I have a co-pay, deductible, out of pocket or co-insurance, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay AAANC for professional and clinic services, including AAANC's physician services, in accordance with the regular rates and terms of AAANC. I also agree to pay for other professional services provided at AAANC by other health care providers. If I am unable to pay, I understand I may qualify for special payment arrangements. I also understand that when this agreement is signed by my spouse, parent or a guarantor, my spouse, parent or guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
4. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to AAANC of any insurance benefits to or on my behalf for AAANC services, including emergency services, at a rate not to exceed AAANC actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to AAANC by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service

______________________________	______________________________	
Signature of Patient	Signature of Patient Representative	
______________________________	______________________________	
Signature of Witness (required if patient unable to sign)	Relationship of Representative to Patient	
______________________________	______________	______________
Signature of Interpreter	Language Used	Date