ALLERGY & ASTHMA
CENTER OF ORLANDO
Shreya Patel MD

Today's Date: / /

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

DOB: _____ Gender: M _____ F _____ SSN: _____-_____-_____

Home #: _____ Cell #: _____ Ethnicity: _____

Home Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Email: _____ @ _____.com Marital Status: _____

EMERGENCY CONTACT:

Emergency Contact Name: _____

Relationship to Patient: _____ DOB: _____

Primary #: _____ Secondary #: _____

INSURANCE INFORMATION:

PRIMARY	SECONDARY
Insurance Name: _____	Insurance Name: _____
Member ID: _____	Member ID: _____
Group #: _____	Group #: _____
Name of Insured Party: _____	Name of Insured Party: _____
Insured's SSN: _____-_____-_____	Insured's SSN: _____-_____-_____
Patient's relationship to the Insured Party: Self ____ Spouse ____ Child ____ Other _____	Patient's relationship to the Insured Party: Self ____ Spouse ____ Child ____ Other _____

I authorize the release of any medical information necessary to process insurance claims and coordinate care with other physicians involved in my healthcare. I assign insurance payment directly to Allergy & Asthma Center of Orlando. I agree to pay all applicable insurance co-pays at the time of service. I agree to provide Allergy & Asthma Center of Orlando with my most current insurance information at all times and to pay all deductibles, coinsurances, and any balance not covered by my insurance upon demand. I agree that copied of the form will be valid as the original.

PATIENT SIGNATURE (or parent if minor): _____ Date: _____

PRIMARY CARE DOCTOR:

PCP Name: _____ Phone Number: _____

Specialty: Internal Medicine ____ Pediatrics _____ Family Medicine _____ Other _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

PREFERRED PHARMACY:

Pharmacy Name: _____ Phone Number: _____

Address: _____City: _____ State: _____ Zip: _____

I, _____ do give permission for the office of Allergy & Asthma Center of Orlando to provide my physician with copies of progress notes (medical information) concerning my office visit to AAC Orlando. The reason for submission of such information is to ensure better continuity of patient care.

PATIENT SIGNATURE (or parent if minor): _____ Date: _____

Skin testing is an office procedure that is used to detect is allergy is present in an individual, and if so, to what allergens an individual may be allergic. This is of value to the diagnosis and treatment of allergy-related illness including Allergic Rhinitis (Hay Fever), Asthma, Urticaria (Hives), Atopic Dermatitis (Eczema), Food Allergy, Insect Allergy, Drug Allergy, Recurrent Ear Infections (Eustachian Tube Dysfunction), Rhinosinusitis & associated Headaches.

Skin testing is done in our office by several different techniques which include:

A. Prick Testing: This is a technique in which the allergen is places on the skin (usually the individual's back) and then the skin is abraded (scratched) with a needle.
B. Prick Multi-Test: This technique includes the allergens being places on a plastic device which is then applied to the patient's skin (usually the individual's back).
C. Derma-Pic: This technique includes the allergens being placed on the individual's skin (usually the back) and then a plastic device (Derma-pic) is used to abrade the skin.
D. Intradermal: The allergen is places into a syringe and is then injected under the skin (intradermal injection). This type of skin testing is limited to the arm. It is the most sensitive way to detect the presence of allergies.

With skin testing, especially with the intradermal technique, the individual may experience mild discomfort with the placement of the allergen. After the skin is applied, the individual may experience some degree of pruritis (itching). A positive skin test will result in an area of inflammation with the possible development of a hive. Although rare, an individual who is skin tested may experience a systemic reaction which could include generalized hives, itching, increased head congestion, and rarely, chest congestion. These reactions, if they do occur, will usually occur within several minutes after the placement of the skin test, and will usually subside within a short period of time. We would like to stress that these reactions are rare, and our office is set up to take care of these possible side effects (complications) of skin testing.

PATIENT SIGNATURE (or parent if minor): _____ Date: _____

Allergy & Asthma Center of Orlando
BRIEF ALLERGY HISTORY

PATIENT'S NAME: _____ DOB: _____

What is the reason for your visit?

_____

_____

How long have these symptoms been present?

_____

_____

When are your symptoms worse? All year-round Spring Summer Fall Winter

What evaluations have you had?

_____

What medications have you tried to control these symptoms?

_____

List all the medications that you are now taking:

_____

_____

Have you had any allergic reaction to any medication? Please list.

_____

_____

Please list all your medical conditions, diagnoses, and any surgeries:

_____

_____

Please list any family medical conditions; especially hay fever, asthma, or eczema:

Mother: _____

Father: _____

Siblings: _____

Children: _____

Other: _____

Do you have any pets at home? Please list.

Allergy & Asthma Center of Orlando
NOTICE OF PRIVACY PRACTICES

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, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured 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.*

How This Medical Practice May Use or Disclose Your Health Information: This medical practice collects health information about you and stores it in a chart on a computer and/or paper chart as an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

Appointment Reminders: We may use and disclose medical information 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: We may disclose your health information 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, unless you had instructed us otherwise, in the event of your death. 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.

Marketing: We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that maybe of interest to 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 Health

Oversight Activities: We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

Law Enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or 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, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

Public Safety: We may, and are sometimes required by law, to 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.

Workers' Compensation: We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Breach Notification: In the case of a breach of unsecured protected health information, we will notify you as required by law.

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, consistent with its legal obligations, 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.

Your Health Information Rights:

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy: You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we
did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs (treatment), (payment), (health care operations), (notification and communication with family) and (specialized government functions) or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to a Paper or Electronic Copy of this Notice: You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices:

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

Complaints: Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer at 407-777-8794.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:
OCRMail@hhs.gov or by calling 1-800-368-1019
The complaint form may be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.
You will not be penalized in any way for filing a complaint.

Allergy & Asthma Center of Orlando
AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

A Notice of Privacy Practices is provided to all patients. This Notice of Privacy Practices identifies: 1.) how medical information about you may be used or disclosed by AAC Orlando 2.) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3.) your rights to complain if you believe your privacy rights have been violated; and 4.) AAC Orlando's responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the information above, received a copy of AAC Orlando's Notice of Privacy Practice, and is the patient, or the patient's personal representative.

_____ _____
Name of Patient or Patient's Personal Representative

Signature of Patient or Patient's Personal Representative

_____ _____
Relationship of Personal Representative to Patient (if applicable)

Date

If applicable, reason patient's written acknowledgement could not be obtained:
_____
_____
_____
Notice Dated 3/5/2018

AUTHORIZATION TO OBTAIN OR DISCLOSE PROTECTED HEALTH INFORMATION "PHI"

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [45 CFR§164.508]. I authorize Allergy & Asthma Center of Orlando, my physician and/or administrative and clinical staff to:

____**Obtain** the following protected health information (PHI) detailed below from:
Name & Address of entity with the records: _____

_____

or

____ **Disclose** the following protected health information to:
Name & Address where the records are to be sent: _____

_____

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Allergy & Asthma Center of Orlando cannot ensure your right to the protection of privacy of this information once it is disclosed to another party.

Please forward copies of the following:

___ Initial History & Physical
___ Progress Notes
___ Clinical Summary
___ Laboratory Results
___ Spirometry Reports
___ Radiology Reports
___ Skin Test Results
___ Serum Mixture (Contents & Concentration)
___ Immunotherapy Schedule
___ Other: _____

Please mail or fax records to:
Allergy & Asthma Center of Orlando
5385 Conroy Road, Suite 104 Orlando Fl, 32811
Fax: 689-208-1222

I understand that this consent is revocable upon written notice to Allergy & Asthma Center of Orlando except to the extent that action has been taken in reliance on this authorization. This authorization is effective through_____(date), if no date entered the authorization is in effect until the patient submits a revocation.

_____ _____
Signature of Patient/Parent/Guardian Patient DOB

_____ _____ _____-_____-_____
Name of Patient Today's Date Patient SSN

OFFICE AND FINANCIAL POLICIES

Thank you for choosing Allergy & Asthma Center of Orlando for your allergy needs. We are committed to providing outstanding medical treatment and care. We understand that many patients find insurance coverage and financial responsibility issues complex and confusing. Due to this, we have outlined our practice's policy in detail to help you.

INSURANCE:

Please have your insurance card available when checking in for your appointment. Also, many insurance plans require you to obtain a referral from your Primary Care Physician (PCP) before receiving services. Please have your referral with you when checking in for your appointment. As a courtesy, we will verify coverage on your behalf. Your provider may perform procedures or services deemed necessary to your health. Not all services or procedures are covered by all insurance contracts. Please be advised that you are responsible for all copays on the day of service. All other payments and coinsurances are to be paid in a timely manner after statements are sent out listing your explanation of benefits.

NO INSURANCE OR SELF-PAY

Payment will be due on the day of service. Price listing for certain services is available upon request, before services are rendered.

RETURNED CHECKS

A $25.00 charge will be added to your account for any check returned by your bank for any reason.

APPOINTMENT CANCELLATIONS & NO SHOWS

If you are unable to keep your scheduled appointment, please call our office 24 business hours in advance to reschedule your appointment. This will enable us to use your time slot to accommodate another patient. Failure to do so will result in a $25.00 fee being charged to your account.

MEDICAL RECORDS:

We will provide you with a copy of your medical records upon request. You will need to sign a letter of release. Please allow 5 business days for us to copy your records. There will be a fee of $1.00 per page for the first 3 pages, then $1.00 per page thereafter. Special forms longer in length are subject to a $25 administration fee. Payment is due upon receiving the records.

Signature: _____ Date: _____

Allergy & Asthma Center of Orlando
CREDIT CARD ON FILE POLICY

Allergy & Asthma Center of Orlando is committed to efficiency and reducing waste. Our goal is to make the billing process as simple as possible. We require that you provide a credit card on file with our office. When you come in, we will scan your card and your payment information will be stored in our secure software through a merchant service company called Square for future transactions. Office personnel will not have access to your card. For your protection, only the last 4 digits of your card will show in our system.

Credit cards on file will be used to pay account balances AFTER insurance claims adjudication.

Once your insurance has processed the claim, they will send an Explanation of Benefits (EOB) to both you and our office showing what your patient responsibility is. You typically receive the EOB before we do so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.

If your total amount you owed is over $200, our office staff will contact you to notify you about the payment and then will process the payment with your credit card on file for up to $200. If we have not received full payment by the next billing cycle, our office manager will charge up to $200 each billing period (every 28-30 days) until your balance is paid in full.

If you have questions about your bill call our office number: (407) 777-8794

Notes:

- During the time you leave a credit card on file, if it expires or otherwise becomes uncollectible, we will expect you to provide a new means of payment.
- Credits on your account, after your insurance claim has been adjusted, will be returned to your credit card on file.
- If your credit card is mistakenly processed, we will immediately issue a refund on the same card.
- Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.

Credit Card on File Authorization:

I agree to place my credit card on file to be charged by Allergy & Asthma Center of Orlando for any outstanding bills for medical services rendered. I authorize staff and/or billing service to utilize my credit card for the purposes stated above and none other.

Signature: _____ Date: _____