Allergy Immunology Clinic Patient Information Form

Patient

Last Name _____ First Name _____ SS _____ Gender M / F DOB (MM/DD/YY) _____

Street Address _____ City _____ State _____ Zip Code _____

☐ (_____) _____ Home Telephone ☐ (_____) _____ Work Telephone ☐ (_____) _____ Cell Phone

Check box(es) if permission granted to leave medical information message.

Spouse/Parent Name _____ Spouse/Parent SSN# _____ S/P DOB (MM/DD/YY) _____ Spouse/Parent Employer _____

Other family members who are patients _____

Billing Information (if different from above)

Last Name _____ First Name _____ MI _____ SSN# _____ Gender (circle) M / F DOB (MM/DD/YY) _____

Street Address _____ City _____ State _____ Zip Code _____

(_____) _____ Home Telephone (_____) _____ Work Telephone (_____) _____ Cell Phone

Insurance

Primary Insurance Carrier _____ Membership # _____ Group # _____

Policy Holder (if different from above)

Policy Holder Full Name _____ Policy Holder SSN# _____ DOB (MM/DD/YY) _____ Relationship to Patient _____

Home Telephone _____ Work Telephone _____ Cell Phone _____ Employer _____

Secondary Insurance

Secondary Insurance _____ Membership # _____ Group # _____

Policy Holder (if different from above)

Policy Holder Full Name _____ Policy Holder SSN# _____ DOB (MM/DD/YY) _____ Relationship to Patient _____

Home Telephone _____ Work Telephone _____ Cell Phone _____ Employer _____

Emergency Information

Emergency Contact Full Name _____ Telephone # _____ Relationship to Patient _____

Primary Care Physician _____ Telephone # _____ Physician Address _____

Referring Physician (if different from above) _____ Telephone # _____ Physician Address _____

Assignment of Benefits I request that payment of authorized benefits be made to the Allergy Immunology Clinic for services received. I authorize medical information to be released to the insurance carrier(s) or to the Health Care Financing Administration and its agents for the purpose of processing the claim and/or determining benefits. This assignment will remain in effect until revoked by me in writing. A payment plan is available and can be arranged through the bookkeeper. Payment of this account is due thirty (30) days after receiving the statement. Your insurance carrier will be billed as a courtesy. However, you are ultimately responsible for payment of the account. A $45 fee will be charged for any checks returned to us by the bank. A $50 fee will be charged for appointments not kept and not cancelled within 24 hours notice.
To the best of my knowledge the information provided herein is accurate and I understand I am responsible for the payment of this account.

Signature _____ Date _____

OFFICE USE ONLY

Verified with patient _____ Updated records _____

NAME: _____

D.O.B. _____ **DATE:** _____

Primary Care Provider:

_____

Reason for your visit today, including duration of symptoms:

_____

Have you had adverse reactions to any prescription medication? If so, what medications

_____

Current medications you are taking prescribed by any doctor:

_____

Current over-the-counter preparations / medications you use:

_____

Have you ever had a pneumonia shot?

_____

Have you had a flu shot for this flu season (August-March)?

_____

Questions you would like to ask during today's visit:

1. _____
2. _____
3. _____
4. _____
5. _____

OFFICE USE ONLY

Verified with patient_____ Updated records_____

Personal Health Information Release

Your personal health information is protected. We will not communicate your personal health information with anyone without your written consent, except with those health professionals with whom we share your care, such as your other physicians, nurse practitioners, physicians assistants and pharmacy personnel. This also includes your insurance carrier(s).

Those other individuals with whom you may share my personal information are as follows:

Name _____ Relationship _____

☐ health and financial
☐ health only
☐ financial only

Name _____ Relationship _____

☐ health and financial
☐ health only
☐ financial only

Name _____ Relationship _____

☐ health and financial
☐ health only
☐ financial only

Name _____ Relationship _____

☐ health and financial
☐ health only
☐ financial only

Signature _____ Date _____

☐ Please do not share any personal information with anyone other than those health professionals involved in my care.

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Notice of Privacy Policy and Practices

Effective date: December 1, 2009

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected health information*, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact: Privacy Supervisor

C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI:

C.1. Treatment.
Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (e.g. blood, urine), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHII to other health care providers for the purposes related to your treatment.

C.2. Payment.
Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

C.3. Health care operations.
Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operation, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

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C.4. Appointment reminders.
Our practice may use and disclose your PHI to contact you and remind you of an appointment.

C.5. Treatment options.
Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

C.6. Health-related benefits and services.
Our practice may use and disclose your PHI to inform you of health-related benefits and services that may be of interest to you.

C.7. Release of information to family/friends.
Our practice may use and disclose your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take his/her child to the pediatrician's office for treatment. In this example, the baby sitter may have access to the child's medical information.

C.8. Disclosure required by law.
Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your PHI:

D.1. Public health risks.
Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

D.2. Health oversight activities.
Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

D.3. Lawsuits and similar proceedings.
Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

D.4. Law enforcement.
Our practice may release your PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

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D.5. Deceased patients.
Our practice may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.

D.6. Organ and tissue donation.
Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

D.7. Research.
Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when it has been determined that the waiver of your authorization satisfies all of the following conditions:

- The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
- The research could not practicably be conducted without the waiver;
- The research could not practicably be conducted without access to and use of the PHI.

D.8. Serious threats to health or safety.
Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

D.9. Military.
Our practice may use and disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

D.10. National security.
Our practice may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We may also disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

D.11. Inmates.
Our practice may use and disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and or (c) to protect your health and safety or the health and safety of other individuals.

D.12. Workers compensation.
Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:

E.1. Confidential communications.
You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the **Privacy Supervisor**, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

E.2. Requesting restrictions.
You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only

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certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the **Privacy Supervisor**. Your request must describe in a clear and concise fashion:

- The information you wish restricted;
- Whether you are requesting to limit our practice's use, disclosure or both;
- To whom you want the limits to apply.

E.3. Inspection and copies.
You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the **Privacy Supervisor**, in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct the review(s).

E.4. Amendment.
You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **Privacy Supervisor**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

E.5. Accounting of disclosures.
All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an "accounting of disclosures" you must submit your request in writing to the **Privacy Supervisor**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

E.6. Right to a paper copy of this notice.
You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **Privacy Supervisor**.

E.7. Right to file a complaint.
If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Privacy Supervisor**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

E.8. Right to provide an authorization for other uses and disclosures.
Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons you described in the authorization. Please note: we are required to retain records of your care.

Again if you have any questions regarding this notice or our health information privacy policies, please contact the **Privacy Supervisor**.

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Privacy Policy and Practises Acknowledgement Form

I acknowledge I have received the policies for privacy of information from the office of David E. Bilstrom, M.D., P.C and that the office is in compliance with both the Health Insurance Portability and Accountability Act (HIPAA) and Red Flag Rule (i.e. protection against personal identity theft). I understand that all information regarding the care I receive in this office will be handled according to these policies and that they conform to the guidelines set forth by the Health Insurance Portability and Accountability Act, a federal government document, as well as the Red Flag Rule, mandated by the Federal Government. I am aware that I may specify with whom my personal information be shared. I realize that my other doctors, pharmacies and my health insurance company are the customary means through which my information will be shared for my benefit.

Signature:..... Date:

Full name:

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