

Allergy and Asthma Medical P.C.

PATIENT REGISTRATION FORM

Today's Date

PATIENT INFORMATION

_____/_____/_____

Please PRINT and COMPLETE ALL SECTIONS

Sex: Male Female Date of Birth: ____/____/_____ Age: _____ yr(s) Social Security# _____

Name: _____ Home address: _____

Last name first name (as it appears on your insurance card) middle initial

(Apt # _____) City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ ext: _____

Cell Phone: (_____) _____ E-mail address: _____

Occupation / Employer Contact Info: _____

Race: _____ Preferred Language: _____ Ethnicity: _____

Emergency Contact Information

Name _____ Relationship to Patient _____

Cell Phone # _____ Home Phone # _____

Who is your Primary Care Physician (i.e. Family physician, Pediatrician)?

Name: _____ Phone #: _____

Address: _____ City _____ State: _____ Zip: _____

Whom may we thank for recommending you to us? (Please check all that applies)

Friend or Family member: Name: _____ Relationship: _____

Insurance Website/Physician Directory A Physician Referral Service Yellow Pages Zocdoc

Another Doctor – Is this the Primary Care Physician listed above? Yes No If you answered no, please list name:

Name: _____ Phone #: _____

PHARMACY INFORMATION

Name: _____

Address (if known): _____

Phone Number: _____

INSURANCE INFORMATION

PRIMARY Insurance: _____ Member ID #: _____

Group #: _____ Co-pay \$ _____

Do you have other insurance coverage other than your primary coverage? No Yes (if so please list below)

SECONDARY insurance: _____ Member ID#: _____

Group#: _____

SOCIAL SECURITY# _____ / _____ / _____

Complete this section IF YOU ARE LISTED AS A DEPENDENT or SPOUSE on your insurance coverage.

GUARANTOR INFORMATION

Guarantor's name: _____ Relationship to Patient: Parent Spouse

Last name First name MI Other _____

Date of Birth _____ / _____ / _____ Social Security # _____ / _____ / _____

Employer's Name: _____ Work Phone: (_____) _____

SAME : Please check this box if the home address is the same as the patient's. If DIFFERENT, WRITE the address below

Address: _____ City: _____ State: _____ Zip: _____

I have read, understand, and agree with the above information about the cost of my medical care today.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I authorize my insurance benefits to be paid directly to Allergy and Asthma Medical PC or it's designee for all medical services rendered. I understand that I am ultimately responsible for any account balance for professional services that my insurance does not cover.

I also authorize Allergy and Asthma Medical PC to release pertinent information to my insurance company as needed to facilitate payment of a claim and to initiate complaints to the insurance commission for any reason on my behalf. I certify that the information I have reported with regard to my insurance coverage is correct and accurate.

I also acknowledge that I have received and understand my rights under the HIPAA Privacy Laws. I further agree that a photocopy of this agreement will be valid as the original.

I authorize the physician(s) to treat myself and/or my child.

X _____

Signature of Policyholder

Date

WAIVER OF REFERRAL AUTHORIZATION

It happens, the patient shows in your office, scheduled or unscheduled, and while you believe a referral is required prior to services being provided, the patient does not have the referral, and may even deny that they have an obligation to provide.

The following has been prepared for those circumstances. It invites the patient to clarify their understanding, and acknowledges their acceptance of responsibility for their representations.

A patient can waive their obligation to obtain, and your obligation to receive, a referral before the provision of services. If an adult, with capacity, waives the referral requirements, and accepts responsibility for the services rendered, then this form will document that waiver for the patient, and the payer.

NOTICE OF PATIENT RESPONSIBILITY

Patient Name: _____
Health Plan Name: _____
Patient Health Plan ID Number: _____

As an enrollee of the above named health plan, I understand that my health plan usually requires a referral from my Primary Care Physician for service provided by this medical practice.

Please review the situations described below and place a check mark by the description that best explains your understanding of why no referral authorization exists.

I did not obtain prior referral authorization from my Primary Care Physician and I am knowingly self-referring for this visit. I understand that I will be responsible for the cost of services provided today.

I did not obtain prior referral authorization from my Primary Care Physician because I do not believe it is required. I understand that if I am incorrect I will be responsible for the cost of these services.

My Primary Care Physician has agreed to refer me for this visit and it appears that this office has not yet received the appropriate referral authorization. I understand that it is my responsibility to contact my Primary Care Physician to confirm this referral and to obtain and provide this office with documentation of the authorization for this visit. If the referral authorization is not confirmed and provided to this office within 48 hours, I will be responsible for the cost of services rendered.

Signature _____

Name: _____

Today's Date: _____

Please be advised of NY Penal Code, Section 176.05

A fraudulent health care insurance act is committed by any person who, knowingly and with intent to defraud, presents, ... a claim for payment, services or other benefit pursuant to such policy, contract or plan, which he knows to: (a) contain materially false information concerning any material fact thereto; or (b) conceal, for the purpose of misleading, information concerning any fact material thereto . . .

The failure to provide accurate information as to your insurance coverage, or the obtainment of services through deception, such as by misstatements, or by the false use of insurance IDs, constitute a fraudulent act.

Such acts are also subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.

NOTICE OF PRIVACY PRACTICES (HIPAA)

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.

At Allergy and Asthma Medical P.C. we respect the confidentiality of your medical information and will protect that information in a responsible manner. We have a comprehensive privacy program in place that meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations. The government legislation that sets standards for the privacy of medical information.

Allergy and Asthma Medical P.C. follows all state privacy laws to which we are subject that do not conflict with the HIPAA Privacy Regulations. However, if a state privacy law conflicts with the HIPAA Privacy Regulations yet provides greater privacy rights or protections than the HIPAA Privacy Regulations, we will follow that state law.

We must follow the privacy practices that are described in this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the changes are permitted by law. Before we make a significant change to our privacy practices, we will change this notice and send the new one to our current patients. This new notice will be effective for all medical information that we maintain, including medical information we created or received before the changes were made. Additionally, please know that Allergy and Asthma Medical P.C. is required by law to maintain the privacy of your medical information and to give you this notice regarding your rights, our privacy practices and legal duties concerning your medical information.

Definition of Medical Information

When we refer to medical information in this notice, we mean information that is Individually Identifiable health information. This includes demographic information collected from you or created or received through your health plan, your employer or a health care clearinghouse. This information relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you or (3) past, present or future payments for the provision of health care to you.

Uses and Disclosures of Medical Information

This section provides you with a general description and examples of the ways your medical information is used and disclosed. Our use and disclosures are not limited to these examples.

Treatment: Your medical information may be used or disclosed to a physician or other healthcare provider in order for them to provide you with treatment.

Payment: Your medical information may be used or disclosed

- for billing, claims management and collections activities,
- to get our claims payments from your insurance carrier
- to determine your eligibility for benefits.
- to conduct risk adjustment activities.
- to obtain "precertification" or "pre-authorization" from your insurance carriers for medically necessary procedures or services.
- to obtain information regarding your premiums, deductibles or co-insurances.

Health Care Operations: Your medical information may be used and disclosed in connection with our healthcare operations, including:

- quality assessment and Improvement activities and protocol development.
- conducting or arranging for medical review, legal services, auditing and fraud and abuse detection and compliance programs.
- business management and general administrative activities, including management activities relating to privacy, patient service and resolution of internal grievances.

Additional Disclosures: Your medical information may be disclosed to other persons or entities that assist us in conducting our payment, health care operations and business activities. We will not disclose your medical information to those persons or entities unless they agree to keep it protected. Health-Related Services: Your medical information may be used to send you appointment reminders or to communicate with you for purposes of treatment, or to direct or recommend alternative treatments, therapies, healthcare providers or settings of care.

To Your Family and Friends: Your medical information may be disclosed to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Your name, location and general condition or death may be used or disclosed to notify or assist in the notification of (including Identifying or locating) a person involved in your care, We will provide you with an opportunity to object to such uses or disclosures, unless, based on professional judgment, we may reasonably infer from the circumstances that you do not object to such uses and disclosures, If you are not present, or In the event of your Incapacity or an emergency, we will use our professional judgment in deciding whether disclosing your medical information would be in your best interest.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by its charter or by law to assist in disaster relief efforts.

For the Public Benefit: Your medical Information may be used or disclosed as authorized by law for the following purposes:

- as required by law for public health activities, Including disease and vital statistic reporting, child abuse reporting, FDA oversight And to employers regarding work-related illness or Injury
- to report adult abuse, neglect or domestic violence
- to health oversight agencies
- in response to court and administrative orders and other lawful processes
- to law enforcement officials pursuant to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and for purposes of identifying or locating a suspect or other person
- to coroners, medical examiners and funeral directors
- to organ procurement organizations
- to avert a serious threat to health or safety
- in connection with certain research activities
- to the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- to correctional institutions regarding inmates
- as authorized by state workers' compensation law

Your Written Authorization Is Required: Other uses and disclosures of your medical information that are not described above will only be made with your written authorization. You may give us written authorization to use or to disclose your medical information to any one for any purpose. You may revoke your authorization at any time. However, your revocation will not affect any use or disclosure that you permitted prior to your revocation.

Your Individual Rights

Access to Your Information: You have the right to inspect or obtain a copy of the medical information about you that is contained in a "Patient chart/folder". A "patient chart/folder" generally contains medical and insurance information as well as other records that are maintained by or for us, or used by or for us to make decisions about you. We may ask you to submit your request in writing and to provide us with the specific information we need in order to fulfill your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies to you. In certain situations, we may deny your request to inspect or obtain a copy of the requested information. If we deny your request, we will notify you in writing and may provide you with an opportunity to have the denial reviewed.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations or those authorized by you as well as for certain other activities that occurred up to six years before the date of your request. However, you will not be able to obtain a list of disclosure instances that occurred prior to April 14, 2003; the date this notice is effective. Any list we send you will include the date(s) of the disclosure, to whom it was made, their address. If known, a brief description of the information disclosed and the purpose of the disclosure. If you request this accounting list more than once in a 12-month period, we may charge you a reasonable administration fee for these additional requests.

Restrictions on Use or Disclosure: You have the right to request that we restrict the use or disclosure of your medical information in connection with treatment, payment and health care operations. You also have the right to request that we restrict disclosures to persons involved in your healthcare or payment for your health care. We may ask you to submit your request in Writing. We will review your request, but we are not required to comply with it.

Confidential Communication: You have the right to request that we communicate with you about your medical information by a different means or location. You must make your request in writing and state that the information could endanger you if it is not communicated by a different means or location. We must accommodate your request if it is reasonable and specifies the new means or location of contact. It must also allow us to collection claims we filed on your behalf. This includes issuing explanations of benefits to the subscriber of the health plan in which you participate. An explanation of benefits issued to the subscriber about the subscriber or others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we received payment, even though we communicated with you in the confidential manner you requested. Once your request for confidential communications is in effect, all of your medical information will be communicated in accordance with your instructions.

Amending Your Medical Information: If you believe that the medical information contained in your "designated record set" is not Correct or complete. You have the right to request that we amend it. We may require your request be in writing and that it explains why the information should be changed. If we make the amendment, we will notify you. In addition, if we make the change, we will make reasonable efforts to inform others. Including people you name, of the amendment and to include the changes in any future disclosures of that information.

Additional Copies, Questions or Complaints

Requests for Additional Copies and Questions Regarding Privacy and Individual Rights:

- You may request a copy of our notice at any time.
- If you view this notice on our website or receive it by e-mail, you are also entitled to receive it in written form.
- You may request more detailed information about your rights and privacy protections or learn how to exercise those individual rights as described in this notice.

Complaints: If you believe that Allergy and Asthma Medical P.C. has violated your privacy rights, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. We support your right to the privacy of your medical Information.