PATIENT INFORMATION:

Today's Date: **Account #:**

Patient Last Name: **First:** **MI:** **Sex:**

DOB: **Age:** **SSN:**

Race:
( ) American Indian or Alaska Native ( ) Asian ( ) Native Hawaiian or Other Pacific Islander
( ) Black or African American ( ) White ( ) Hispanic
( ) Other Race ( ) Other Pacific Islander ( ) Prefer Not to Respond

Ethnicity (pick one): ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) Prefer Not to Respond

Patient Address:

Home: **Cell:** **Work:**

Email:

Employer: **Employer Address:**

Emergency Contact Name: **Phone #:**

Emergency Contact Relationship to Patient:

Marital Status: ___S ___M ___W ___D *(If married, answer the section below.)*

Spouse Name: Spouse DOB: Spouse SSN:

Spouse Cell #: Spouse Work #:

Spouse's Employer:

Referring Physician (if applicable): Phone #:

Primary Care: Phone #:

How did you hear about our practice?

Pharmacy Name:

Pharmacy Location: **Pharmacy Phone Number:**

FINANCIAL INFORMATION:

RESPONSIBLE PARTY INFORMATION:

If you are 18 or older, you are considered to be the responsible party. If you are your own Responsible Party, you can skip this section.

If the patient is a minor, please fill in the following information completely.

Relation to Patient: ___Mother ___Father ___Guardian ___Other: _____

Responsible Party Name: _____ **DOB:** _____ SSN: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

INSURANCE AND POLICY HOLDER INFORMATION:

POLICY 1 (Primary Insurance):	Insurance Holder Relationship to Patient: ___Self ___Spouse ___Mother ___Father ___Guardian
	Policy 1:
	Policy #: Group #:
	Policy Holder Name: **Policy Holder DOB:**
	Policy Holder SSN: Policy Holder Phone #: ( )
	Policy Holder Address:

POLICY 2 (Secondary Insurance):	Insurance Holder Relationship to Patient: ___Self ___Spouse ___Mother ___Father ___Guardian
	Policy 2:
	Policy #: Group #:
	Policy Holder Name: **Policy Holder DOB:**
	Policy Holder SSN: Policy Holder Phone #: ( )
	Policy Holder Address:

Today's Date: _____ Patient Name: _____ Account #: _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. I understand that I am responsible for any amount not covered by my insurance.

I authorize the release of any medical information necessary to process insurance claims filed on my behalf or on behalf of my dependent.

Signature: _____ **Date:** _____

I authorize payment of medical benefits to be made directly to the supplier or provider for services rendered.

Signature: _____ **Date:** _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *The Allergy, Asthma & Sinus Center, Allergy Associates PA* for services furnished me by that provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ **Date:** _____

I request that payment of authorized Medigap/Supplement benefits be made on my behalf to *The Allergy, Asthma & Sinus Center, Allergy Associates PA* for services furnished me by that provider/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits.

Signature: _____ **Date:** _____

MARKETING ACKNOWLEDGEMENT:

As a patient of *The Allergy, Asthma & Sinus Center,* please circle the response that applies to you.

YES or **NO** I would like to receive information via mail or email about new products or services.

Signature: _____ **Date:** _____

Today's Date: _____ Patient Name: _____ Account #: _____

AUTOMATED CONFIRMATION NOTICE:

To better serve you, The Allergy, Asthma & Sinus Center has implemented an automated appointment reminder system to provide you with the courtesy of a timely, efficient reminder of your next appointment. You have the option to receive either a phone call confirmation or a text message confirmation. If you so choose, you can opt out of receiving any appointment reminders. Please initial beside the appropriate selection below.

_____ I would like to receive a phone call for appointment reminders/confirmations. I want to receive my appointment reminder/confirmation calls at this phone number: _____

You will be able to either confirm or cancel your appointment using your telephone keypad. You will receive a call three (3) days prior to your appointment to inform you of vital information such as the name of the provider you are scheduled to see and the date, location and time of your appointment. If you do not confirm your appointment at this time, you will receive a second abbreviated appointment reminder call two (2) days before your appointment. If you are unavailable when you are called and you have a voicemail or answering machine, the system will leave you a brief message. If you are unable or fail to press the correct key when you receive a confirmation call, please contact our scheduling department at (865) 584-0962 or (800) 600-7551.

_____ I would like to receive a text message for appointment reminders/confirmations.

You will receive a text message to confirm your appointment three (3) days before your appointment. You will be able to confirm this appointment by responding with 'YES' and a unique pin number. If you need to cancel or reschedule your appointment, we ask that you call our scheduling department at (865) 584-0962 or (800) 600-7551.

_____ I do **not** want to receive **any** appointment reminders via call or text message.

My preferred time to receive appointment reminders is:

_____ Morning _____ Afternoon _____ Evening

Allergy Associates, PA, dba The Allergy, Asthma & Sinus Center

Patient Name: _____ Chart #: _____ (08/17)

HIPAA DISCLOSURE

I understand that under the Health Insurance Portability & Accountability Act, (HIPAA), of 1996 I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in my medical record at The Allergy Asthma & Sinus Center, (AASC), or may be received from outside health entities and filed in my medical record. I understand that this information can and will be used by AASC to: (a) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly, (b) obtain payment from third-party payers, (c) conduct normal healthcare operations such as quality assessments and physician certifications, (d) notification of educational events specific to my medical condition through AASC or networking organizations, and (e) to researchers for IRB approved research, if I am a participant in a clinical trial. I understand that AASC or its business associate may contact me to provide appointment reminders, and information about treatment alternatives and other health-related benefits and services that may be of interest to me.

I understand that AASC may provide health information to assist in my care or for identification purposes in the event of a disaster unless I express my objection to such disclosures on this Acknowledgment.

☐ I agree ☐ I object

I have been informed of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand AASC has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 6701 Baum Drive, Suite 140, Knoxville, TN 37919. I understand that I may request, in writing, that AASC restrict how my private information is used or disclosed to carry out my treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but, if you do agree, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time except to the extent that I have taken action relying on this consent.

Signature: _____ Date: _____
Patient/Parent/Guardian

RELEASE OF INFORMATION AUTHORIZATION

☐ AASC **may not** discuss my healthcare and **may not** discuss and/or make financial arrangements with any immediate family member.
☐ AASC **may** discuss my healthcare and **may** discuss and/or make financial arrangements with any immediate family member.
☐ AASC **may not** discuss my healthcare, but **may** discuss and/or make financial arrangements with any immediate family member.
☐ AASC **may** discuss my healthcare, but **may not** discuss and/or make financial arrangements with any immediate family member.
☐ AASC **may** discuss my healthcare, and **may** discuss and/or make financial arrangements **with only the individuals listed below**:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I prefer to be contacted in the following manner:

Phone Number: _____ Phone Number: _____

☐ Leave a message with contact number only. ☐ Do NOT leave a message.

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO THE FOLLOWING INDIVIDUALS OR COMPANIES:

Allergy Associates, PA, dba The Allergy, Asthma & Sinus Center Phone: (865) 584-2411 Fax: (865) 584-6384

Signature: _____ Date: _____
Patient/Parent/Guardian

ePrescribing Consent

ePrescribing is defined as a physician's ability to electronically send an accurate, error-free and understandable prescription to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an ePrescribing program.

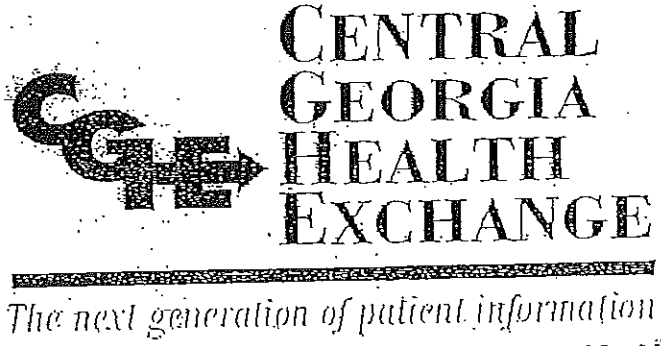
These include:

- ☐ Formulary & Benefit Transactions: Gives the prescriber information about which drugs are covered by the drug benefit plan
- ☐ Medication History Transactions: Provides the physician with information about medications the patient is already taking to minimize the opportunity of potential adverse drug interaction
- ☐ Fill Status Notification: Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription was picked up, was not picked up or was partially filled

By signing this consent form, you are agreeing that Allergy Associates, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes and that Allergy Associates, PA may share information related to your medications and/or health with other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Allergy Associates PA to enroll me in the ePrescribe Program. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction

Signature: _____ Date: _____
Patient/Parent/Guardian



Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers.

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not wish to participate in the Central Georgia Health Exchange electronic medical record at this time

Printed Name of Patient	*Patient Date of Birth*	*Printed Name of Representative*

Signature of Patient or Representative	*Date Signed*

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient): _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your healthcare provider's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange,MSC 98 777 Hemlock Street, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to my other healthcare providers (including, but not limited to, participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors Offices) through the *Central Georgia Health Exchange*.