**ADVANCEMENTS IN ALLERGY AND ASTHMA CARE, LTD.**

Consent and Payment Authorization Form B”H

**Please read, provide your initials next to each category and sign the document below. By signing, you acknowledge that you have read, understand and agree with the Consent and Payment Authorization Form and the conditions stated within.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

##  Consent for Treatment

I authorize Advancements in Allergy and Asthma Care, Ltd. (“AAAC”) to provide any treatment, including the performance of the diagnostic tests, procedures, and/or the administration of the medications which may be deemed appropriate by the physician, provider or other personnel involved in my care. I understand that persons receiving medical training may be involved in my care.

 **Consent and Authorization for Release of Information**

I consent to the release and use by AAAC of medical and other information about me to the extent permitted by law to a health care provider being advised or consulted in connection with my treatment or care; a health plan, insurer, third-party payer, third-party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies; and to a person or organization in connection with AAAC’s health care operations (e.g. interdisciplinary healthcare conferences, quality improvement activities, performance evaluations, business management, and other related activities).

I consent to the release of medical and other information about me to the following other individuals (e.g. spouse, family member, coach, trainer, employer, etc):

I understand this consent will continue until revoked, which can be done at any time by providing written notice to AAAC.

 **Payment Authorization**

**Payment Responsibility.** I agree to pay for all services furnished to me by AAAC, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third party payers, upon receipt of statement, except as prohibited by AAAC’s contract with my health plan or applicable law. I also agree to pay or reimburse AAAC for all costs it may incur in collecting such amounts, including, but not limited to, attorneys’ fees and collection agency fees.

**Payment Authorization.** I authorize AAAC to directly bill my health plan or third-party payer for services rendered to me by or on behalf of AAAC, but acknowledge that AAAC is not obligated to submit claims to third-party payers on my behalf unless required by law or by its contracts. I also authorize any third-party payer through which I may have benefits to make payment directly to AAAC for such services. I understand and agree that AAAC is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

**Statement to Permit Payment for Medicare Benefits.** If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to AAAC, for any services furnished to me by AAAC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Written Name of Patient (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient If Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason Patient is Unable to Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADVANCEMENTS IN ALLERGY AND ASTHMA CARE, LTD.**

Notice of Privacy Practices B”H

**Please read and sign below. By signing, you acknowledge that you have read and understand the Notice of Privacy Practices.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Confidentiality.**  It is the policy of Advancements in Allergy and Asthma Care, Ltd. (“AAAC”) to protect the privacy and confidentiality of patients’ medical information and to comply with the Health Insurance Portability and Accountability Act (HIPAA).

**Notice of Privacy Practice.** AAAC’s Notice of Privacy Practices explains how AAAC may use and disclose my medical information. It also explains my rights regarding this kind of information. AAAC may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices upon request. AAAC’s Notice of Privacy Practices can be obtained by contacting the clinic.

Signature of Patient (or legal guardian): Date:

**ADVANCEMENTS IN ALLERGY AND ASTHMA CARE, LTD.**

Medical, Educational and Emergency Contact Information B”H

**Please complete or correct the fields below to help us keep more accurate records of who would potentially request your medical information or who we should contact in case of an emergency.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Medical Providers**

**Primary Provider Referring Provider**

Physician/Provider Name: Physician/Provider Name:

Clinic Name: Clinic Name:

Phone Number: Phone Number:

City, State: City, State:

**Educational Institution**

School Name: City, State:

Phone Number: Fax Number:

**Emergency Contacts**

Contact Name 1: Contact Name 2:

Relationship to Patient: Relationship to Patient:

Phone Number: Phone Number:

City, State: City, State:

**Other Individuals (for Parents or Legal Guardians only)**

In addition to the parents or legal guardians of the patient, the following person(s) are authorized to recommend medical care for my child. This authorized person must be 18 years of age or older. While your child visits our clinic, a parent or legal guardian **MUST** be available by phone during the appointment for any person(s) named below.

Name of authorized person(s):

Relationship to patient:

**ADVANCEMENTS IN ALLERGY AND ASTHMA CARE, LTD.**

Patient Medical History B”H

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Have you ever had surgery or an overnight hospitalization**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Any other medical conditions/diagnoses (i.e. high blood pressure, heart problems, diabetes, etc.)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Prescription and over the counter medications including dose (or bring your prescription bottles with you)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Family Social History** | **Please Circle or Describe** |
| Does your mother have  | allergy asthma chronic sinusitis N/A |
| Does your father have | allergy asthma chronic sinusitis N/A |
| How many siblings do you have  |  |
| How many of your siblings have | ( )allergy ( )asthma ( )chronic sinusitis |
| **Adult Social History** |
| What is your occupation |  |
| Are you  | Single Married Divorced Other  |
| Number of children |  |
| **Child Social History (only for patients under age 18)** |
| Education level |  |
| Child custody status |  |
| Child lives with |  |
| **Other Social History**  |
| Living arrangements | Single Family Home Apartment Other  |
| What is your Housing heating source | Forced air Water Wood  |
|  | **Yes** | **No** |  |
| Are you exposed to mold |  |  |
| Have you lived in another part of the country/world in the past 5 years |  |  | If yes, where |
| Do you have any contact with animals/pets (home or daycare) |  |  | If yes, please list |
| Any feather/down comforter, pillow or jacket |  |  |  |
| Is your diet normal |  |  |  |
| Any caffeine use |  |  | If yes, how much |
| Any alcohol use |  |  | If yes, how much |
| Do you take any vitamin D |  |  | If yes, how much |

|  |  |  |
| --- | --- | --- |
| **Smoking History** | **Yes** | **No** |
| Are you exposed to smoke |  |  |
| Are you a current or former smoker |  |  |
| If yes, \_\_\_\_\_\_ pack(s) per day for \_\_\_\_\_ years.If you quit, when |
| Any other types of tobacco use:Cigars Chew Pipe |

|  |
| --- |
| **Immunizations** |
| Date of most recent flu vaccine: |
| Date of Pneumovax: |
| Date of Prevnar 7 or Prevnar 13: |
| Date of Tdap (tetanus with whooping cough): |

|  |  |  |
| --- | --- | --- |
| **Imaging** | **Yes** | **No** |
| Have you ever had sinus x-ray or CT scan? If yes, list test name and date. |  |  |
|  |
| Have you ever had chest x-ray or CT scan? If yes, list test name and date |  |  |
|  |

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information will be reviewed with you during your appointment.