Allergy & Asthma Center

2625 Box Canyon Drive
Las Vegas, NV 89128

Patient Information

Patient Name (Last) (First) (M.I.)	DOB:	SSN:
Home #	Cell #	Work #
Marital Status S M D W	Sex: M F	Age:
Address:		Appt #
City:	State:	Zip:
Referring Physician Phone#	Primary Physician Phone#	
Emergency Contact	Phone #	

Email Address:

Guarantor Information

Guarantor Name: (Last) (First) (M.I.)	SSN:
Address (If different)	DOB:
Employer	Occupation

Insurance Information (Please have receptionist copy your insurance cards)

Primary Insurance Co:			Phone #
Policy Holders Name:	DOB:	SSN:	
Claims Address:	City:	State:	Zip:
Policy ID#	Group #	Effective Date:	
Secondary Insurance Co:			Phone #
Policy Holders Name:	DOB:	SSN:	
Claims Address:	City:	State:	Zip:
Policy ID#	Group #	Effective Date:	

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor. A copy of the signature is as valid as the original.

______________________ ______________________ ________

Patient Signature **Guarantor Signature** **Date**

Allergy & Asthma Center
Joel Katz, MD Brenda Brechler, APN
2625 Box Canyon Drive
Las Vegas, NV 89128

Financial Policy

All patients must complete our financial policy before seeing the physician or nurse practitioner

Thank you for choosing Allergy and Asthma Center as your health care provider. Our charges reflect what is usual and customary. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- Co-pays, co-insurance and unmet deductibles are due at time of service.
- There is a $35.00 fee for returned checks.
- We accept cash, checks, MasterCard/Visa/American Express/Discover.
- There may be a late cancellation fee of $35.00 for appointments missed or not cancelled before 24hrs.

Regarding Insurance

We will bill your insurance as a courtesy, if within the United States. Current insurance information is required for billing. You (patient or responsible party) are responsible for any co-payments, co-insurances, deductibles, plus any balance due on non-covered services from your plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of your services provided may be non-covered by your medical insurance, in which case you will be responsible for the charges of those services.

- For insurance plans where Allergy & Asthma Center is a participating provider and which require a co-payment, all co-payments are due at time of service. In the event that your insurance coverage changes to a plan for which we are not participating, refer to the above paragraph; you will be responsible for the charges for those services. If you fail to provide our office with updated insurance information in a timely manner you will also be held responsible for the outstanding balance.

Minor Patients

- The adult (parent, guardian) accompanying a minor is responsible for the co-payment at time of service. (A divorce decree does not determine which party Allergy & Asthma Center will bill for medical services. Divorce decrees are only binding upon the two parties who made the agreement.)
- The parent accompanying the child(ren) on the first appointment will be considered the guarantor (responsible party) on the patient's account. The guarantor is responsible for co-payments at time of service.

Payments

- Financial Information may be provided to Guarantor, Subscriber, or the party paying the bill.
- The guarantor (responsible party) is responsible for all out of pocket at time of service.
- Past due accounts greater than 90day are subject to third party action.

If you have any further questions regarding your account please call 702-360-6100.

I have read the policies above and understand and agree to this Financial Policy.

____ _______________

Signature of Patient or Responsible Party Date

____

Patient's name if minor

Notice of Privacy Practices
For Allergy & Asthma Center ("the practice")

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.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this notice. This notice describes our privacy practices. You can request a copy of this notice at any time.

Protected Health Information (PHI)
"Protected health information" is medical information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present and future payment for health care.

Treatment, Payment, Health Care Operations

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for health care operations, and to evaluate the quality of care that you receive. These disclosures may be made in writing, electronically, by facsimile, or orally.

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physicians in this practice are specialists. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions. Other examples are when the practice provides information to a pharmacy to fill a prescription, to a diagnostic facility to order x-rays, ct's, or to a lab to order lab tests.

Payment
We are permitted to use and disclose your medical information to determine eligibility for benefits, get approval for a recommended treatment, and to bill and collect payment for the services provided to you. For example, we may submit a claim form to obtain payment from your insurer. The claim will contain medical information such as a description of the medical service provided to you that your insurer needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the service of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke the authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Nevada law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, license applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated.
- Pertains to a person who has died under circumstances that may be related to criminal conduct.
- Is about a victim of crime and we are unable to obtain the person's agreement.
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation

We may disclose your medical information as required by Nevada's workers compensation law.

Inmates

We may release your medical information to a correctional institution or law enforcement official if you are an inmate or under the custody of law enforcement. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit your letter attention privacy officer.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. Please send your written request to the office manager at the Allergy & Asthma Center's office where you are seen.

Inspection and Copies of Protected Health Information

You may inspect and/or obtain a copy of health information that is within the designated record set, which is information that is used to make decisions about your care. Nevada law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the office manager at the Allergy & Asthma Center.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information that is the subject of the request;

- Was not created by this practice or the physician/providers in this practice.
- Is not part of the Designated Record Set.
- Is not available for inspection because of an appropriate denial.
- Is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made with an authorization signed by you or your representative.

Appointment Reminder, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, treatment plans, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The Contact information is:
U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact the office manager at the Allergy & Asthma Center.

This notice is effective on April 14, 2003
We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgment of Receipt
Notice of Privacy Practices
Allergy & Asthma Center

I have received a copy for review of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive my own copy of this document.

____
Signature of Patient or Guardian/Personal Representative

____
Date

____
Name of Patient or Guardian/Personal Representative (Please Print)

____
Description of Guardian/Personal Representative's Authority

Allergy & Asthma Center
Joel Katz, MD   Brenda Brechler, APN
2625 Box Canyon Drive
Las Vegas, NV 89128
Tel 702-360-6100 Fax 702-360-8096

Release form for Minor Patients

Date: ______________________

I _______________________________ consent to my child ______________________ receiving treatment, allergy shots, and any resultant emergency treatment, which may be necessary in my absence.

Signed: ____
Parent or Guardian's Name

Print Name: ____

I ______________________________________ do not wish for my child to be treated by the Allergy & Asthma Center without my being present.

Signed: ____
Parent or Guardian's Name

Print Name: ____

Allergy & Asthma Center
Joel L. Katz, MD
Diplomate American Board Of Allergy & Immunology

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: ____

____

To Release to: **Joel Katz, MD**
2625 Box Canyon Drive, Las Vegas, NV 89128

Patient Name: ____

SSN# ______________________________ DOB: ________________

Information to be released:
Entire Record
Clinical Notes
Lab/X-ray or Diagnostic test results
Other: __________________________

I give permission for release of any information in my medical record, including information relevant to substance abuse, psychiatric or mental health services, and/or HIV/AIDS information, unless specifically excluded as noted below.

DO NOT RELEASE Information Related To: HIV/AIDS Substance Abuse
Psychiatric or Mental Svcs
Other: ______________________________

____ ______________________
Patient (Parent/Guardian) Signature Date

____ ______________________
Witness Signature Date

I____ hereby give authorization to release any information relating to my medical treatment to other physicians, medical facility, radiology or hospitals.

____ ______________________
Patient (Parent/Guardian) Signature Date

2625 Box Canyon Drive
Las Vegas, Nevada 89128
Phone: 702-360-6100 Fax: 702-360-8096

Patient History Form

Name______________________________________ **Age**__________ **Date**________________
Referring Physician________________________________ **Primary Physician**_________________________________
Reason for Visit____
____
____

<u>Past Medical History</u>

Surgeries: (Name and Date of Procedure)

____ ____
____ ____
____ ____

Medical illnesses/conditions: (Name and Date diagnosed)

____ ____
____ ____
____ ____
____ ____
____ ____

Hospitalizations: (Reason and Date)

____ ____
____ ____

Drug Allergies: None________________
Drug___________________________ Date/Age____________Reaction____
Drug___________________________ Date/Age____________Reaction____
Drug___________________________ Date/Age____________Reaction____
Drug___________________________ Date/Age____________Reaction____
Drug___________________________ Date/Age____________Reaction____
Drug___________________________ Date/Age____________Reaction____
____
____

Food Allergies: None_______________
Food _____________________ Date/Age____________Reaction____
Food _____________________ Date/Age____________Reaction____
Food _____________________ Date/Age____________Reaction____
Food _____________________ Date/Age____________Reaction____
Food _____________________ Date/Age____________Reaction____
Food _____________________ Date/Age____________Reaction____
____

Contact Allergies:
Are you allergic to any creams, detergents, soaps, etc?
____
____

Insect Allergies:
Have you ever had a life-threatening reaction to a stinging insect? ____
____

Smoking History:
Current: How much per day? ______________________ How Long? __________________________
Past: How much per day? ______________________ How Long? _____________________________
Does anyone in your home smoke? ____

Current Medications:
Please list all current medications and dosages:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

PATIENT INSTRUCTIONS BEFORE ALLERGY TESTING

Medications that need to be stopped 3 days prior to your visit:

All Antihistamines

- Alavert
- Allegra
- Astelin
- Astepro
- Atarax
- Benadryl
- Cetirizine
- Chlor-Trimeton
- Clarinex
- Claritin
- Dimetapp
- Diphenhydramine
- Doxepin
- Fexofenadine
- Loratadine
- Patanase
- Pepcid
- Periactin
- “PM” or “cold” medication
- Sinequan
- Tagamet
- Vistaril
- Xyzal
- Zantac
- Zyrtec

Medications that are safe to use before your visit:

All Asthma Inhalers
Singulair
Prednisone
Medrol
Decongestants

DO NOT STOP MEDICATIONS FOR OTHER CHRONIC CONDITIONS

If you have a question about a specific medication, please contact our office.