Allergy, Asthma & Immunology Clinic, P.A.

General Consent

Consent to Treat

I consent to and authorize the physicians, nurses and other healthcare providers at Allergy, Asthma & Immunology (AAIC) to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to Allergy, Asthma & Immunology. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with AAIC to get payment for my care. If I am eligible for payment from more than one type of coverage, AAIC will return any extra payments to the payor. If I have an unpaid bill at AAIC, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from AAIC.

Release of Information

I consent to and authorize Allergy, Asthma & Immunology to use and disclose my protected health information for:

- Treatment
- Payment
- Healthcare Operation Purposes, including care coordination and quality assessment and improvement activities.

Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to AAIC and/or a clinically integrated network or accountable care organization in which AAIC participates.

Patient Rights and Privacy Practices

You and your family's rights and our privacy practices are posted in main areas within Allergy, Asthma & Immunology. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or Allergy, Asthma & Immunology's Privacy Officer.

Other Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child: name and relationship to patient (e.g., grandma, grandpa, daycare provider, etc.):

Name:	**Relationship to child:**
1._____	_____
2._____	_____
3._____	_____

Release of Information for Research Purposes

I consent to and authorize the release of my protected health information for medical and scientific research purposes.
(*Check only if refusing to consent*) _____

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Signature: _____ **Print Name:** _____ **Relationship to Patient:** _____

Parent Email Address: _____ **Name of Interpreter (if used):** _____

Telephone consent obtained by (Name/Date/Title): _____

PATIENT REGISTRATION AND CONSENT FORM

Patient Information

First Name: _____ Last Name: _____ M.I. _____

Address: _____City/State/Zip: _____

Home Phone: (_____) _____-_____ Cell (_____) _____-_____**Marital Status**: □ Married □ Single □ Divorced □ Separated □ Widowed

Date of Birth: _____ **Sex**: □ Male □ Female **Social Security Number**: _____

E-Mail Address (*For clinic communication use only)* _____

Country of Birth: □ United States □ Mexico □ Iraq □ Somalia □ Declined □ Other (specify) _____

Race: □ White □ African American □ Asian □ Hispanic □ American Indian □ Pacific Islander □ Declined □ Other (specify) _____

Primary Language: □ English □ Spanish □ Chinese □ Arabic □ Somali □ Declined □Other Specify)_____

May AAIC leave messages on your Home Phone? _____ (y/n) Work Phone? _____ (y/n) Cell? ____ (y/n)

Employer Name: _____ Work Phone: (_____) _____-_____

Employer Address: _____ City/State/Zip _____

Primary Care Physician: _____ Clinic Name: _____

Referring Physician-*if not Primary Physician*: _____ Clinic Name-*if different*: _____

Emergency Contact *Relationship to Patient:* □ Spouse □ Parent □ Step Parent □ Legal Guardian

First Name: _____ Last Name; _____

Address : _____ City/State/Zip: _____

Home Phone:_____ Cell Phone: _____Work Phone: _____

*If patient is a minor please fill out the following information:

Mother's Name: _____ Cell Phone: _____ Work: _____

Father's Name: _____Cell Phone: _____ Work: _____

Responsible Party □ Self □ Spouse □ Parent or Guardian □ Other_____:

First Name: _____ Last Name: _____ MI _____

Birth Date: _____ Social Security Number: _____

Address: _____ City/State/Zip: _____

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

Employer: _____Employer Address: _____ City/State/Zip _____

Insurance Information: Policy Holder Name _____*Relationship to patient:*_____ *Date of Birth* _____

Insurance Company: _____ ID Number: _____ Group#: _____

Employer: _____ Address: _____ City/State/Zip _____

Secondary Insurance-Policy Holder Name: _____*Relationship to patient*: _____

Insurance Company: _____ ID Number: _____ Group#: _____

Employer: _____ Address: _____ City/State/Zip _____

Pharmacy Information

Pharmacy Name: _____ Location (City):_____

Mail Order Pharmacy: _____ Phone Number: _____

Pharmacy Insurance ID# (*if applicable*) _____

How did you hear about us?

□ Newspaper Ad (Press or Stillwater) □ Brochure □ Employee □ Internet □ Clinic Website

□ Physician/Nurse Referral □ Friend/Relative □ Yellow Pages □ Hospital □ Insurance Directory

Please read the statements below and initial.

1. **I authorize release of any medical information necessary to process my claim for services provided by AAIC. _____**(Patient/Guardian Initials)

2. **I authorize payment directly to AAIC. _____** (Patient/Guardian Initials)

3. **I authorize release of my health records to any provider who is being advised or consulted with in connection to my current treatment. _____**(Patient/Guardian Initials)

4. **I authorize AAIC to view my prescription history electronically from other pharmacies through our EMR (electronic medical record) system. _____**(Patient/Guardian Initials)

I understand that I am responsible for the charges for all services rendered toward myself or the Patient, by Allergy, Asthma, & Immunology Clinic, P.A. (referred to throughout this document as "AAIC"). As the Patient/Responsible Party, I understand that I am personally responsible to ensure payment on any account balance within thirty (30) days of services rendered. If for any reason insurance does not pay for a portion of the account balance, I will make prompt arrangements to pay the account myself. I understand that an AAIC account becomes past-due after 120 days. I further understand that if I neglect to make payments on a past-due account, AAIC will use an attorney for collection and that I shall be personally responsible for all reasonable costs of collection. I also understand that AAIC shall charge an interest rate of five percent (5%) on all past-due accounts.

I understand that it is my responsibility to obtain pre-authorization for treatment, if required by insurance, and that I am responsible for any charges insurance does not pay because pre-authorization was not obtained. I further understand that co-payments or other payments that insurance plans do not cover for services rendered by AAIC are due at the time of service. In the event my insurance carries a deductible over $1,000.00, I understand that AAIC reserves the right to collect fifty-percent (50%) of the payment up-front, prior to service.

Payments to AAIC may be made in cash, by personal check, or on a MasterCard or Visa. I understand that personal checks returned without sufficient funds will result in a $25.00 NSF fee.

It is AAIC's policy to strive to comply with all state and federal laws regarding patient privacy. I acknowledge that I have been offered a copy of AAIC's Notice of Privacy Practices as posted in the reception area. I also understand that I have a right to receive a copy of these privacy practices at any time upon request.

Patient/Guardian's Signature: _____ Relationship to Patient: _____ Date:_____

THIS SIGNATURE DOES NOT EXPIRE. YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.