Allergy & Asthma Center
2625 Box Canyon Drive
Las Vegas, NV 89128

PLEASE PRINT NEATLY

Patient Information

Patient Name (Last) (First) (MI)		**DOB:**	**Social Security Number:**
Home Phone #:	**Cell Phone #:**		**Work Phone #:**
Marital Status: S M D W	**Sex: M F**		**Age:**
Street Address:			**Apartment or Unit #:**
City:	**State:**		**Zip:**
Referring Physician:	**Phone #:**	**Primary Physician:**	**Phone :**
Emergency Contact:		**Phone #:**	
Email Address:	**Employer:**		**Occupation:**

Guarantor Information (if other than patient)

Guarantor Name: (Last) (First) (MI)		**SSN:**
Address (if different):		**DOB:**

Insurance Information

Primary Insurance Company Name:			**Phone #:**
Subscriber's Name:	**DOB:**		**SSN:**
Patient's Relationship To Subscriber:	**Subscriber's Employer**		
Claims Address:	**City:**	**State:**	**Zip:**
Policy ID #:	**Group #**		**Effective Date:**
Secondary Insurance Company Name:			**Phone #:**
Subscriber's Name:	**DOB:**		**SSN:**
Patient's Relationship To Subscriber:	**Subscriber's Employer**		
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 proceeding 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

2625 Box Canyon Drive
Las Vegas, NV 89128

Patient/Practice Agreement and Financial Policies

Consent for Treatment

I consent to medically necessary evaluation and treatment for myself or for a minor for whom I am the legal guardian.

Financial Policies: I acknowledge my full financial responsibility for services rendered by the Allergy and Asthma Center. I understand that co-pays, co-insurance, and unmet deductibles are due at the time of service. 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 copayments, co-insurance, deductibles, and/or 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 possibly 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.

In the event that your insurance plan changes, you are responsible for informing the Allergy and Asthma Center of this change, determining whether Allergy & Asthma Center is a participating provider for the new plan, and determining what the new co-pays, co-insurance, and deductibles are. In the event that your insurance coverage changes to a plan with which we are not participating or if you fail to provide our office with updated insurance information in a timely manner, you will be responsible for the outstanding balance that results.

There is a fee of $30.00 for appointments missed or not cancelled at least 24 hours prior. If the office is closed, patients may call the main number and leave a message with the answering service to cancel appointments.

There is a $35.00 fee for returned checks.

Minor Patients: The adult (parent, guardian) accompanying a minor is responsible for the minor's co-payment at the time of service. The parent or guardian accompanying the child(ren) to the first appointment will be considered the guarantor (responsible party) on the patient's account. The guarantor is responsible for co-payments at the time of service. If I am accompanying a minor to an appointment, I declare that I am the lawful guardian of this minor and that there are no court orders in effect at the time of service that would prohibit me from giving legal consent for the minor's medical treatment.

Release of Information: 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. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceeding due to lack of payment on my part, I agree to pay any and all collection fees and legal fees that may be added to my account in order to recover monies due to the doctor. I further agree that all legal proceedings will occur in Las Vegas. A copy of the signature is as valid as the original.

Thank you for choosing the Allergy & Asthma Center as your health care provider. If you have any further questions regarding your account, please call (702) 360-6100.

I have read all of the policies above and understand and agree to these policies.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Patient's name if patient is a 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
- 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 worker's 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 Parent/Guardian or Personal Representative

_____

Signature of Patient or Parent/Guardian or Personal Representative

_____

Date

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

Release form for Minor Patients

Date: _____

I _____ consent for my child _____ to receive treatment, allergy shots, and any resultant emergency treatment, which may be necessary in my absence.

Parent/Guardian Signature: _____

Print Name: _____

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

Parent/Guardian Signature: _____

Print Name: _____

Allergy & Asthma Center
Joel Katz, MD ~ Brenda Brechler, APRN
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Las Vegas, NV 89128
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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: _____

_____

To Release to: **Allergy & Asthma Center**
Joel Katz, MD Brenda Brechler, APRN
2625 Box Canyon Drive, Las Vegas, NV 89128

Information re 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 Health Services_____ Other: _____

_____ _____
Patient or Parent/Guardian Signature Date

_____ _____
Witness Signature Date

Allergy & Asthma Center
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2625 Box Canyon Drive
Las Vegas, Nevada 89128
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Use and Disclosures of Public Health Information

To Whom May We Release OR Discuss Information Regarding Your Healthcare/Billing/PHI*?
(Family and/or Friends)

Information will not be released to anyone without your written consent.
You may change this information at any time.

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Patient Name: _____ Date of Birth: _____
(Printed Name)

Patient Signature: _____ Date: _____
(Parent or Guardian if patient is a minor)

*PHI: Protected Health Information
01/19

Patient History Form

Name_____ **Age**_____ **Date**_____
Referring Physician _____ **Primary Physician** _____
Reason for Visit_____
_____
_____

Past Medical History

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

Medications that are safe to use before your visit:

All Asthma Inhalers
Nasal Steroids
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.