ARIZONA ASTHMA AND ALLERGY INSTITUTE

PATIENT REGISTRATION

PATIENT INFORMATION		
Patient #:	Gender: Race:	Date of Birth:
Last Name:		Age:
First Name: Initial:		Social Security #:
Address:		Home Phone:
City, State, Zip: Primary Care Physician: Email:		Work Phone: Mobile Phone:

RESPONSIBLE PARTY		
Account #	Patient Relationship to Guarantor:	
Last Name:		Gender: Marital Status:
First Name:		Date of Birth:
Address:		Social Security #:
City, State, Zip:		Home Phone:
Employer: Work Phone: Employer Address: City, State Zip:		

INSURANCE INFORMATION		
Primary Insurance:		Policy/Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:
Second Insurance:		Policy Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION	
Parent/Legal Guardian Name:	**Emergency Contact:**
Address:	Address: Patient relationship to Contact:
Parent Home Phone:	Contact Home Phone:
Parent Work Phone:	Contact Work Phone:

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize Arizona Asthma and Allergy Institute to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. I hereby authorize Arizona Asthma and Allergy Institute to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

X_____ Date:_____

Signature

13965 N. 75th Avenue
Peoria, Arizona 85381

13860 N. Northsight Blvd
Scottsdale, Arizona 85260

4140 E. Baseline Rd., Suite 112
Mesa, AZ 85206-4413

13026 W. Rancho Santa Fe Blvd, Suite A-100
Avondale, AZ 85323-1712

3200 E. Camelback Rd., Suite 125
Phoenix, AZ 85018-2325

NAME: _____ AGE: _____ DATE: _____

D.O.B.: _____ SEX: _____

PRIMARY CARE PHYSICIAN:_____

REFERRED BY: _____

WHAT PROBLEMS DO YOU WANT EVALUATED (Circle)

1. Hay fever or nasal problems
2. Eye symptoms
3. Sinus and/or Ear problems
4. Breathing difficulties- Asthma, bronchitis, cough, etc.
5. Skin problems- Hives or swelling, eczema, or other rash
6. Insect reaction (local swelling)
7. Drug reaction
8. Food reaction
9. Headaches
10. Other

WHAT ARE YOUR SYMPTOMS (Circle appropriate symptoms)

Nasal Symptoms

how many years?
nasal discharge- clear, yellow, green
post nasal drip
sneezing
nasal itchiness
nasal congestion
frequent nose blowing
loss of smell/taste
throat itchiness
daily, weekly, seasonal?

Sinus Symptoms

frequent sinus infections
facial pain and tenderness
tooth pain
pressure and congestion
colored nasal discharge
headaches

Chest Symptoms

cough, wheeze, shortness of breath
how long?
daily, weekly, or monthly?
chest tightness
waking up at night
how many nights per week?
do you cough up anything? What color?
have you tried any inhalers or albuterol?
do you have a nebulizer or breathing machine?
do you have a peak flow meter?
how many severe episodes in the last year?
have you used prednisone or oral steroids?
have you been to the emergency room?
have been hospitalized for the chest symptoms? When?
do you have stomach reflux?
do you have problems with exercise?

Eye Symptoms

itchiness, redness, puffiness
watery discharge
eyelid irritation
dark circles under eyes
do you use eye drops?

Skin symptoms

hives, welts, red patches, itchiness
eczema
areas of swelling
how long?
Family history of swelling or eczema?
recent infection?
recent antibiotic use?

WHAT TRIGGERS YOUR SYMPTOMS? (Circle) (Beside each circled item, N=nasal, C=chest)

ALLERGIES			INFECTION			OTHER		
pollens (grass, weeds, trees)	N	C	viral colds	N	C	antibiotics	N	C
animals (cat, dog, horse)	N	C	sinus infection	N	C	aspirin	N	C
mold/mildew	N	C				chemicals	N	C
dust	N	C				insects	N	C
foods	N	C				other		
IRRITANTS			**IRRITANTS**			**UNKNOWN**		
weather changes	N	C	woodstove/fireplace	N	C	emotions	N	C
wind	N	C	strong odors	N	C	stress	N	C
cold air/humidity	N	C	perfumes/chemicals	N	C	laughter	N	C
exercise	N	C	tobacco smoke	N	C	crying	N	C

PATIENT NAME: _____

CIRCLE WHICH MONTHS YOU HAVE SYMPTOMS

Nose/Ears	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Sinus	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Breathing	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Skin	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

ENVIRONMENTAL HISTORY (Circle)

Current residence: city_____Length at this location_____
Previous locations:_____
Resident type: House Condo Apt Mobile home
Landscaping: Desert Grass Trees Decorative gravel / rock
Neighborhood: Residential Rural Agricultural Industrial Business
Heating: Gas Electric Wood stove Other
Cooling: Air conditioning Swamp cooler Central Room only None Other
Allergen air filtration: None Small bedside Electronic HEPA
Smokers at home? N Y If yes, who:_____
Flooring: Carpet Tile Wood Linoleum Area rugs Concrete
Bedroom: Box spring mattress Waterbed Bunk bed Futon Mattress covered in plastic
Pillows: Polyester Foam Feather None
Animal Exposure: None Cat Dog Horse Rabbit Hamster Gerbil Bird
In bedroom In House Outside only Parents/Baby sitters
Work: Type of work_____ Number of work days missed over the past 12 months_____
Are your symptoms worse at work? N Y Describe_____
School: Daycare Elementary Junior High High School College
Number of school days missed over the past 12 months _____
Are your symptoms worse at school? N Y Describe_____
If daycare- is there exposure to: animals wood stoves tobacco smoke

CURRENT MEDICATIONS (List medicines taken for <u>any</u> reason including aspirin, blood pressure, thyroid, nose sprays, etc.)

Name of medication	**Dose**	**How often taken**	**Additional medications**

PRIOR ALLERGIC REACTIONS

Drug Reaction: Medication_____Reaction_____
Medication_____Reaction_____
Medication_____Reaction_____

Insect Reaction: Insect type_____Reaction_____
When did this occur?
Symptoms: tongue or throat swelling hives shortness of breath wheeze local swelling

Food Reaction: What were you eating?_____
Time from eating to onset of reaction?
Symptoms: tongue or throat swelling hives nausea vomiting diarrhea shortness of breath wheeze

PREVIOUS ALLERGY CARE (Circle those that apply)

1) Never tested before
2) Tested before: skin tests blood tests
Negative Positive Grass Weeds Trees Dust Animals Molds Foods
3) Allergy shots? N Y If yes, name of doctor and locations_____
Dates_____to_____ Degree of help: None Slight Moderate Great
4) Previous sinus x-ray or CT scan?
5) Previous ENT or Pulmonary evaluation?
6) Previous CXR?

PATIENT NAME: _____

Form 200

Patient Past Medical, Family, and Social History

Have you had any of the following	**Yes**	**No**	**Describe the problem when appropriate**
1. Abnormal chest x-ray	☐	☐	
2. Anesthesia complications	☐	☐	
3. Anxiety, depression or mental illness	☐	☐	
4. Blood problems (abnormal bleeding or anemia)	☐	☐	
5. Diabetes	☐	☐	
6. Growth removed from the colon or rectum	☐	☐	
7. Hepatitis	☐	☐	
8. High blood pressure	☐	☐	
9. High cholesterol or triglycerides	☐	☐	
10. Sexually transmitted disease	☐	☐	
11. Stroke or TIA	☐	☐	
12. Treatment for alcohol and/or drug abuse	☐	☐	
13. Tuberculosis or positive tuberculin skin test	☐	☐	
14. Cosmetic or plastic surgery	☐	☐	

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing an (x) in the following appropriate boxes. If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. (Circle) the appropriate choice when multiple choices are listed in a question:

	Medical Problem	Surgery	Year(s) of Surgery	Describe
1. Eyes (cataracts, glaucoma)	☐	☐		
2. Ears, nose, sinuses, or tonsils	☐	☐		
3. Thyroid or parathyroid glands	☐	☐		
4. Heart valves or abnormal heart rhythm	☐	☐		
5. Coronary (heart) arteries (angina)	☐	☐		
6. Arteries (aorta, arms, legs)	☐	☐		
7. Veins or blood clots in the veins	☐	☐		
8. Lungs (pneumonia, valley fever)	☐	☐		
9. Esophagus or stomach (ulcer, reflux)	☐	☐		
10. Bowel or appendix	☐	☐		
11. Liver or gallbladder	☐	☐		
12. Pancreas	☐	☐		
13. Hernia	☐	☐		
14. Lymph nodes or spleen	☐	☐		
15. Kidneys or bladder	☐	☐		
16. Bones, joints or muscles	☐	☐		
17. Back, neck or spine	☐	☐		
18. Brain (headaches, seizures, depression)	☐	☐		
19. Skin	☐	☐		
20. Females: breasts, uterus, tubes, ovaries	☐	☐		
21. Males: prostate, testes, vasectomy	☐	☐		

Pediatric History (Please fill out this section if patient is <12 years old)

Pregnancy: ☐ Full term ☐ Preterm Describe_____
Complications during pregnancy_____
Labor and delivery: ☐ Normal ☐ Complications Describe_____
Newborn nursery course: ☐ Normal ☐ Complications Describe_____
Growth and development: ☐ Normal ☐ Complications Describe_____
Immunizations up to date: ☐ Yes ☐ No
History of RSV infection?

PATIENT NAME: _____

FAMILY MEDICAL HISTORY (Indicate any medical, allergic, or respiratory disorders)

Mother _____

Father _____

Brother/Sister _____

Grandparents _____

Other _____

SOCIAL HISTORY

Education: How many years of school have you completed?

Occupations: Your current employment status: ☐ Employed ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed

Employed-current occupation(s): _____

Previous Occupations/Jobs: _____

Spouses Employment _____

Parent's Employment _____

Disability: Are you disabled: ☐No ☐Yes _____

Abuse: Have you ever been physically, sexually, or emotionally abused? ☐No ☐Yes _____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used	Type/Amount/Frequency	How Long? (Years)	If stopped, when?(Years)
Tobacco	☐Yes ☐No	☐Yes ☐No			
Alcohol-beer wine, liquor	☐Yes ☐No	☐Yes ☐No			
Caffeine-coffee, tea, soda	☐Yes ☐No	☐Yes ☐No			
Recreational/Street drugs	☐Yes ☐No	☐Yes ☐No			

Marital Status: Are you currently married? ☐No ☐Yes In what year did this marriage occur? _____

List any previous marriages (year married and duration): _____

Current Spouse: ☐Not applicable ☐Alive (Name_____) ☐Deceased

Health problems or cause of death: _____

Reviewed and annotated by: (Physician only)

Signature	Date	Signature	Date

PATIENT NAME: _____

Form 201

REVIEW OF SYSTEMS

Indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking Yes or No for each question. Circle the symptom(s) you have experienced when multiple symptoms are listed in a question. If yes, please explain.

	YES	NO	Notation
1. Skin rash, hives, itchiness, dry skin?	☐	☐	
2. Un -healing sores, excessive bruising or change of a mole?	☐	☐	
3. Excessive thirst or urination?	☐	☐	
4. Weight gain or loss, cold intolerance, or tremor?	☐	☐	
5. Change in sexual drive or performance?	☐	☐	
6. Significant headaches, seizures, blurred speech or difficulty moving an arm or leg?	☐	☐	
7. Numbness or tingling of hands or feet?	☐	☐	
8. Eye problems such as double vision, cataracts or glaucoma?	☐	☐	
9. Diminished hearing, dizziness, hoarseness, sinus problems or nasal polyps?	☐	☐	
10. Do you wear dentures? (If yes: ☐Full ☐Upper ☐Lower ☐Partial)	☐	☐	
11. Bothered with cough, shortness of breath, wheezing or asthma?	☐	☐	
12. Coughing up sputum or blood?	☐	☐	
13. Exposed to anyone with tuberculosis	☐	☐	
14. Blacked out or lost consciousness?	☐	☐	
15. Chest pain or pressure, rapid or irregular heart beats	☐	☐	
16. Awakening at night with shortness of breath?	☐	☐	
17. Abnormal swelling in the legs or foot?	☐	☐	
18. Pain in the calves of your legs when you walk?	☐	☐	
19. Difficulty with swallowing, heartburn, nausea, vomiting or stomach trouble?	☐	☐	
20. Problems with constipation, diarrhea, blood/changes in bowel movement?	☐	☐	
21. Have you had a colon or rectum x-ray?	☐	☐	
22. Have you undergone protoscopy, sigmoidoscopy, or colonoscopy?	☐	☐	
23. Difficulty starting your urinary stream or completely emptying your bladder?	☐	☐	
24. Leaking urine or blood in the urine?	☐	☐	
25. Burning sensation or pain with urinating	☐	☐	
26. Pain, stiffness or swelling in your back, joints or muscles?	☐	☐	
27. Fever within the last month?	☐	☐	
28. Enlarged glands (lymph nodes)?	☐	☐	
29. Experiencing an unusually stressful situation?	☐	☐	
30. Weight gain or loss of more than 10 pounds during the last 6 months?	☐	☐	
31. Problems falling asleep, staying asleep, sleep apnea or disruptive snoring?	☐	☐	
32. Abnormal nipple discharge or a breast lump?	☐	☐	
33. Have you ever felt a need to cut down on your alcohol consumption?	☐	☐	
34. Do relatives/friends worry or complain about your alcohol consumption?	☐	☐	
35. Have you been physically, sexually, or emotionally abused?	☐	☐	
QUESTIONS 36-43 TO BE ANSWERED BY FEMALE PATIENTS ONLY:			
36. Have you ever had an abnormal Pap smear? ☐Unknown	☐	☐	
37. Have you experienced menopause or had a hysterectomy?	☐	☐	
38. If no: Are you concerned about your menstrual periods?	☐	☐	
39. Might you be pregnant at this time?	☐	☐	
40. Date or onset of your last menstrual period: mo: day: yr:	☐	☐	
41. Approximate date of your last Pap smear or pelvic exam: mo: day: yr:	☐	☐	
42. Approximate date of your last mammogram: mo: day: yr:			
43. Number of: Pregnancies_____ Live Births_____ Miscarriages/abortions_____	☐	☐	

Reviewed and annotated by: (Physician only)

Signature	Date	Signature	Date

Welcome To Our Practice!

Thank you for choosing AAAI to partner in your healthcare needs. We are committed to providing you with quality and affordable health care. Below are our office and financial policies. Please take a moment to read this in its entirety. If you require additional clarification, or have questions about these policies, please contact our office and we will happy to assist you. A copy will be provided upon request.

- **Phones.** Telephones are answered Monday thru Friday from 8:00 am to 5:00 pm.

- **Emergencies.** Our practice has limited coverage for patient emergencies that may occur after hours. If a problem arises between 5:00 pm and 10:00 pm on weekdays simply call the office main telephone number at (602) 843-2991 and the answering service will contact the doctor on call. Your call will be returned in a timely manner during these hours. **Please note that routine prescription refills and referrals are not considered emergencies and will not be done after hours.**

- **Prescriptions.** All prescription refill requests should be called in to your pharmacy. Your pharmacy will then contact the office if authorization is needed. Your refill requests will be handled by the practice within 24 hours after your pharmacy's request is received.

- **Test Results.** Should you have any laboratory work or other diagnostic testing done through our practice, you will be notified of the results as soon as they are available. All results must first be reviewed by the provider. After review, you will be notified.

- **Records Release.** It takes our office 5 business days to process medical records requests. Medical records will be released to any physician upon your written request and authorization as a courtesy. The fee for "non-treatment" medical records release is $6.50 and payment is required upon release of the medical record(s).

- **Forms Completion.** Completion of forms for insurance purposes, such as application for insurance coverage, disability, or FMLA leave, will be billed to the patient, or representative that requests completion of the forms, at a fee of $30.

- **Telephone Consultations.** Our office charges for telephone consultations initiated by the patient or the patient's guardian. Fees are updated in conjunction with the Center for Medicare and Medicaid Services fee schedule updates.

- **Referrals/Authorizations.** Referrals/authorizations from your Primary Care Physician or Insurance Carrier approving visits to our office, diagnostic facilities, or labs can take several days to retrieve. **You are required to contact your Primary Care Physician (PCP) at least 1 week in advance to notify them of your appointment.** Failure to do so my result in your referral/authorization being denied by your PCP and/or insurance company; therefore making you responsible for any and all charges incurred during your visit.

- **Insurance and Payment Policies**

    - **Proof of Insurance. We ask that you present your insurance card to us at every visit.** If you fail to provide us with the correct insurance information at each visit, you may be responsible for payment for all services provided.
        - Your health insurance contract is between you and your insurance company. Knowing your insurance benefits is your responsibility. Any questions or complaints regarding your coverage should be directed to your insurance company.
        - We are contracted with most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at the time of service. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full is required until we can verify your coverage.
        - If you are uninsured please contact our Business Office at (602) 843-2991, and dial ext. 8071, to obtain quotes for impending services.

    - **Co-Payments/Deductibles.** Your insurance company requires us to collect co-payments and/or deductibles at the time of service. Waiver of co-payments and/or deductibles may constitute fraud under state and federal law and/or the contract terms of your insurance company. Please help us in upholding the law, and complying with the contract terms of your insurance company, by paying your co-payment and/or deductible at each visit.

    - **Non-covered Services.** Please be aware that some or all of the services you receive may be non-covered or not considered medically necessary by your insurer. You must pay for these services in full.

- **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claim(s) paid. Your insurance company may need you to supply certain information directly. It is your responsibility to promptly comply with their request.

- **Account Balances.**
  - Account balances are to be paid in full unless acceptable payment arrangements have been established with our billing office.
  - Payments made to satisfy account balance(s) will always be applied to oldest date(s) of service.
  - If you need assistance coordinating payment from your insurance company, establishing a payment plan, or have difficulty making your co-pay or deductible, please contact the Business Office at (602) 843-2991 ext. 8071.
  - It may be necessary for our business office to contact you regarding your bill. Phone calls are made to the phone number(s) that you provide on the Patient Registration Form. This serves as notification that we may contact your mobile phone for verbal communication if it is listed in your paperwork. If you do not wish to be contacted on your mobile phone, please provide us with an alternate number where you prefer to be reached.
  - Unpaid balances over 90 days will be referred to a collection agency for resolution.
  - Non-payment of account balances and/or account balances placed with a collection agency will result in your records being placed in an "inactive" status, and you will be discharged from our medical practice. **Discharged patients may not register for future appointments or receive subsequent medical care for any reason from AAAI until the account balances are fully satisfied.** No exceptions will be made for urgent or emergent care needs for a former patient with inactivated records for any reason. **If your records are inactivated and you become ill or have an urgent or emergent medical condition, you should seek help at the nearest hospital emergency room, urgent care center, or from your primary care physician.**
  - Outside collection action may result in additional fees for which you will be responsible. These fees include, but not limited to, collection fees, attorney fees, and court fees.
  - If you as the patient are 18 years or older; and a dependent under your parent's insurance you will be listed as the guarantor on this account. Adult children who are mentally incapacitated or have been assigned an adult court appointed guardian will have their parent or guardian listed as the guarantor. If parent chooses to remain as guarantor, then they should also sign our Policy. **Guarantor: Person who should receive and pay the bill for any balance owed, such as a balance not billed to or paid by insurance.**

- **Allergy Immunotherapy (Allergy Shots).** Allergy immunotherapy is a highly effective and affordable treatment for severe allergies affecting quality of life. Allergy Serum is mixed annually and contains enough doses to cover the recommended yearly regimen. Most insurance plans cover allergy immunotherapy and will generally pay a portion of the charges billed for this service.

  The out-of-pocket cost to the patient for this service is determined by your individual insurance plan benefit and related copay(s), co-insurance and/or deductible. High Deductible Health Plans (HDHPs) typically result in a higher cost share for the patient; however, we offer many flexible payment options to help you and insure you receive the medical care that you need. If you are interested in allergy immunotherapy and would like a customized estimate based on your specific insurance plan, please contact our business office at (602)-843-2991, ext. 8071, and a member of our billing team will be happy to assist you.

- **Pre-Registration.** When you schedule an appointment for any of our office locations, you may be contacted by one of our Pre-Registration staff to obtain and/or verify your demographic and insurance information prior to your visit. Providing this information will save you time the day of your service. The Pre-Registrar will take time to explain your insurance coverage and any deductibles or co-insurance that may be due from you.

- **Notification of Health Insurance Changes.** If your health plan has changed, you are responsible for notifying us as soon as possible. If we are not aware of the change(s), you could be held liable for the full cost of your visit by your health plan. Shot Lab patients are to notify the Front Desk of any changes.

- **Dual Custody of Children.** In cases where parents have dual custody over a minor child, or where there is a legal document assigning rights to one parent, our policy is to assign financial responsibility to the parent who authorizes treatment for the child. This authorizing parent is responsible for paying the guarantor's share of the treatment costs. If you are in this situation, and there is a legal document

assigning financial responsibility to another party, it is your responsibility to make payment arrangements with the other party in advance of the child's appointment, and to ensure that payment flows through you to AAAI for the treatment.

- **Returned Check Fee.** A $35 Returned Check Fee will be assessed for checks that are returned to us by your financial institution for insufficient funds.

- **Missed Appointments/Cancellations.** A $25 Missed Appointment fee will be assessed for appointments not cancelled or rescheduled with a minimum of **24 hours advance notice.** This fee will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment(s).

Thank you for understanding our policies. Please let us know if you have any questions or concerns.

I have read and understand the office policies and agree to abide by their guidelines:

_____ ____/____/____

Signature of Patient or Responsible Party Date

_____

Please Print Name

Arizona Asthma & Allergy Institute

Patient No-Show/Cancellation Policy

In keeping with our goal to provide each patient with the highest standard of care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. "No-shows" or last minute cancellations leave empty appointment times for patients in need of medical care. For this reason, **a fee of $25 may be imposed for missed or cancelled appointments with less than 24 hours notice.**

Please note that no-show/late cancellation fees are patient responsibility and will not be billed to your insurance company.

Thank you in advance for your consideration and for allowing us to partner in your healthcare needs.

4140 East Baseline, Suite 112
Mesa, Arizona 85206-4413
480/545-4000 • Fax 480/545-4025

13860 N. Northsight Blvd.
Scottsdale, Arizona 85260-3654
480/451-6756 • Fax 480/451-8679

13965 N. 75th Avenue
Peoria, Arizona 85381
602/843-2991 • Fax 602/978-1226

13026 West Rancho Santa Fe Blvd., Suite A-100
Avondale, Arizona 85392-1712
623/935-3000 • Fax 623/535-9561

3200 E. Camelback Rd, Suite 125
Phoenix, Arizona 85018-2325
602/734-0370 • Fax 602/840-3101

Arizona Asthma and Allergy Institute
Notice of Privacy Practices

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.

Arizona Asthma and Allergy Institute ("AAAI") is dedicated to maintaining the privacy of your protected health information ("PHI"). This Notice will tell you about the ways we may use and disclose PHI. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI. We are required by law to maintain the privacy of PHI, to provide you with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. We are required to abide by the terms of this Notice as may be in effect from time to time.

We may revise our privacy practices at any time by posting a new notice of our privacy practices in our office in a prominent location, and will be posted to our website. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all PHI that AAAI maintains: past, present, or future.

We may use PHI for the following purposes without your authorization:

1. **Treatment**: We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition.
2. **Payment**: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations**: We may use and disclose health information to operate our business. For example, PHI may be used to evaluate the quality of care we provide, for state licensing, to identify you by name when you visit the office, or to our doctors, nurses, technicians and staff for educational and learning purposes. We participate in some organized health care arrangements consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals and may share said information.
4. **Appointment Reminders**: We may use and disclose your information to remind you of appointments. We may communicate with you by any reasonable means to remind you of upcoming appointments.
5. **Treatment Options**: We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. **Business Associates**: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering or quality assurance. Our Business Associates agree to protect the privacy of your PHI.

We may also use and disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- When we suspect abuse, neglect, or domestic violence.
- For health oversight activities.
- For certain judicial and administrative proceedings.
- For law enforcement purposes.
- To a medical examiner, coroner, or funeral director.
- For organ, eye, or tissue donation purposes if you are an organ donor.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military or veterans activities or for national security.
- In any other instance required by law.
- For research purposes.

Unless you object, we may use or disclose your medical information in the following circumstances:

- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose information to notify or assist in notifying a family member, legal representative, or another person responsible for your care or payment for your care. Information may also be disclosed after your death to a family member, other relative, close personal friend, or other person identified by you, unless this would be inconsistent with your known express preference.
- **Emergency Circumstances and Disaster Relief.** We may disclose information about you to an entity assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share the medical information about you, if necessary for the emergency circumstances.

You should also know that:

a. **We will not use or disclose your individually identifiable protected health information for "marketing" purposes (as defined by HIPAA) without your prior authorization, other than face-to-face communications to you, and other than promotional gifts of nominal value that we may provide to you.**
b. **We will not disclose your individually identifiably protected health information in any non-research related manner that would constitute a "sale" (as defined by HIPAA) without your prior authorization.**
c. **If you elect to personally pay for your services "out of pocket" in full, we will agree to any request you make to not bill your health plan or inform them of the services rendered and for which you paid.**
d. **Other uses and disclosures of individually identifiable protected health information not described herein will be made only with your authorization.**

BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure**: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request, except as provided above if you request us to restrict disclosure to a health plan for payment or health care operations if the PHI relates only to a health care item or service for which you have paid in full. If we agree to restrict a use or disclosure, we are bound to the agreement unless the use or disclosure is otherwise required or authorized by law.
2. **Confidential Communications**: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access**: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial in some circumstances.
4. **Amendment**: You have the right to request amendments to your health records created by and for AAAI if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. **Accounting of Disclosures**: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures AAAI has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice**: You have the right to request that we provide you with a paper copy of this Notice of Privacy Practices.

If you have questions about this notice, please contact AAAI's Privacy Officer at 13965 N. 75th Avenue, Peoria, AZ 85381, by email at T.McGee@azsneeze.com, or at (602) 843-2991. If you feel your privacy rights have been violated, you may file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with AAAI, contact our Privacy Officer at the above address. You will not be penalized for filing a complaint.

I have received a copy of this office's Notice of Privacy Practices.

Printed Patient Name	Name/Relationship if Signed by Individual Other than Patient
Signature	Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided was Emergent

_____ Other: _____

Employee Name Date

Arizona Asthma & Allergy Institute

Previous Medications Used

Patient Name / Label

_____

DOB _____

Please indicate what medications you have tried in the past that DID NOT WORK.

Eyes

- □ Bepreve
- □ Elestat
- □ Emadine
- □ Lastacaft
- □ Patanol
- □ Pataday
- □ Pazeo
- □ Optivar
- □ Zaditor
- □ Other_____

Nose

- □ Flonase
- □ Nasacort
- □ Nasonex
- □ Omnaris
- □ Qnasl
- □ Rhinocort
- □ Veramyst
- □ Zetonna
- □
- □ Astelin / Astepro
- □ Dymista
- □ Patanase
- □ Atrovent 0.03/0.06

- □ Allegra Syrup, 30mg, 60mg, 180mg, D
- □ Clarinex Syrup, 5 mg, D
- □ Claritin (Loratadine) Syrup, 5mg, 10mg, D
- □ Zyrtec (Ceterizine) Syrup, 5mg, 10mg, D
- □ Xyzal (Levocerizine) Syrup, 5mg
- □ Benadryl
- □ Other_____

Skin

- □ Cutivate
- □ Elidel
- □ Hydrocortisone
- □ Mometasone
- □ Protopic
- □ Triamcinolone
- □ Other_____

Lungs

- □ Advair 100/50, 250/50, 500/50
- □ Advair HFA 115/21, 230/21
- □ Breo Ellipta 100/25, 200/25
- □ Dulera 100/5, 500/5
- □ Symbicort HFA 80/4.5, 160/4.5
- □ Aerospan 80
- □ Alvesco 80, 160
- □ Arnuity 100, 200
- □ Asmanex 110, 220
- □ Flovent 44, 110, 220 or Diskus 50, 100, 250
- □ Pulmicort 90, 180, SVN respules (budesonide)
- □ Qvar 40, 80

- □ Accolate
- □ Singulair (Montelukast) 4, 5, 10
- □ Zyflo
- □ Daliresp
- □ Other_____

- □ Albuterol HFA (Pro-Air, Proventil, Ventolin)
- □ Albuterol SVN (nebulizer)
- □ Xopenex HFA
- □ Xopenex SVN (levalbuterol)
- □ Combivent
- □ Stiolto
- □ Anoro Ellipta
- □ Atrovent (Ipratropium bromide)
- □ Incruse
- □ Spiriva 1.25, 2.5
- □ Turdoza

- □ How many Prednisone bursts or Medrol Dose packs have you had in the last 12 months?
  _____

Stomach

- □ Dexilant
- □ Nexium
- □ Prevacid
- □ Prilosec (Omeprazole)
- □ Zantac (Ranitadine)
- □ Tums
- □ Other

Arizona Asthma & Allergy INSTITUTE
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Greenway Patient Portal Intake Form

AAAI has a HIPAA secure patient portal that complements your electronic health record. To send you the invite so you can access the portal, we need to enter your email into the system.

Please write clearly and legibly so we can enter the correct email address into the system.

NAME:_____ DOB_____

EMAIL ADDRESS:_____

We also have appointment software that will remind you of appointments. The system can send the reminder by text to cell phone, email and voice. Please list your phone numbers. Please circle which is the preferred method to receive the reminder.

CELL:_____ HOME PHONE:_____

Please circle preferred first contact: cell home

Please circle your preferred method of contact: text email voice no cell or email

Note: A cell phone must be listed as preferred if you request text messages with current and future software developed for patient communication.

CONSENT TO LEAVE DETAILED PHONE MESSAGES OR RELAY INFORMATION THROUGH MY DESIGNATED REPRESENTATIVE

I understand that as part of my healthcare and treatment, Arizona Asthma & Allergy Institute may need to reach me by phone.

( ) I **DO** authorize Arizona Asthma & Allergy Institute to speak with:

_____ or leave a message on my:

( ) home telephone ( ) cell phone ( ) work phone

regarding communication of my healthcare / treatment such as instructions for procedures, clinical, billing, and/or appointment needs.

( ) I **DO NOT** authorize Arizona Asthma & Allergy Institute to leave a message on my home phone, cell phone, or work phone regarding communication of my healthcare / treatment such as instructions for procedures, clinical, billing, and/or appointment needs. **I understand that selecting this option may result in delayed communication of pertinent treatment information such as appointment confirmations, billing communications or clinical call backs. I understand that I will be responsible to make appointments to obtain this information.**

_____ _____
Print Patient Name Print Name / Relationship if signed by individual other than patient

_____ _____
Signature Date