



I, _____, do hereby authorize a representative from National Allergy, Asthma, and Urticaria Centers of Charleston to speak with the following person(s) regarding my: (please check all that apply)

<i>Name</i>	<i>Relationship</i>	<i>Phone Number</i>	<i>Medical Care</i>	<i>Appointments</i>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Do you give the above representative(s) authorization to the following information:

I do I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), sexually transmitted diseases, psychiatric care, psychological assessment and treatment for alcohol and/or drug abuse.

I do **NOT** wish for any medical information/appointments be released to any representative on my behalf.

(Signature of Patient)

(Date)

(Witness)

(Date)

This form will not be valid until patient rescinds authorization in writing.

NOTICE OF PRIVACY

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your Protected Health Information (PHI)

Each time you visit National Allergy & Asthma a record of your visit is made. We are legally required to protect the privacy of this record containing your PHI. We collect or receive this information about your past, present or future health condition, to provide health care to you, to receive payment for this healthcare, or to operate the offices.

HOW WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION (PHI)

A. The following uses do NOT require your authorization, except where required by SC law:

- 1. For treatment.** Your PHI may be discussed by caregivers to determine your plan of care. The physicians and nurses may share PHI in order to coordinate the services you may need.
- 2. To obtain payment.** We may use and disclose PHI to obtain payment for our services from you, an insurance company or a third party.
- 3. For health care operations.** We may use and disclose PHI for hospital and/or clinic operations. For example we may use the information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- 4. For public health activities.** We report to public health authorities as required by law, information regarding births, deaths, various diseases, reactions to medications and medical products.
- 5. Victims of abuse, neglect or domestic violence.** Your PHI may be released as required by law, to the South Carolina Department of Social Services when cases of abuse and neglect are suspended.
- 6. Health oversight activities.** We will release information for federal or state audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, as required by law.
- 7. Judicial and administrative proceedings.** Your PHI may be released in response to a subpoena or court order.
- 8. Law Enforcement or National Security purposes.**
- 9. Use and disclosures about patients who have died.** We provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.
- 10. To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may release the limited information to law enforcement personnel or persons able to prevent or lessen such harm.
- 11. For worker's compensation purposes.** We may release your PHI to comply with worker's compensation laws.

12. Appointment-reminders and health-related benefits and services. We may contact you with a reminder that you have an appointment for check-up or treatment.

- B. You may object to the following uses of PHI: Information shared with family, friends or others.** Unless you object, we may release your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care.

- C. Your prior written authorization is required (to release your PHI) in the following situations:** Any uses or disclosures beyond treatment, payment or healthcare operations and not specified in parts A & B above.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

Although your health record is the physical property of National Allergy & Asthma, the information belongs to you, and you have the following rights with respect to your PHI:

- A. The Right to Request Limits on How We Use and Release your PHI.** You have the right to ask that we limit how we use and release your PHI. We will consider your request but we are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Your request must be in writing and state (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse; and (4) expiration date.

- B. The Right to Choose How We Communicate PHI to You.** You have the right to request that we communicate with you about PHI in a certain way or at a certain location (for example, sending information to your work address rather than your home address). You must make your request in writing and specify how and where you wish to be contacted.

- C. The Right to See and Get Copies of Your PHI.** You have the right to inspect and receive a copy of your PHI, which is contained in a designated record set that may be used to make decisions about your care. You must submit your request in writing. If you request a copy of the information, we may charge a fee for copying, mailing or other costs associated with your request. We may deny your request to inspect and receive a copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

- D. The Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI.** This list may not include instances such as those made for treatment, payment, or health care operations, directly to you or your family. This list may not include uses for which a signed authorization has been received or disclosures made.

- E. The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we amend the existing information or add the missing information. You must provide the

request and your reason for the request in writing. We may deny your request in writing if the PHI is correct and complete or another facility's report.

F. The Right to Receive a Paper or Electronic Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

G. The Right to Revoke an Authorization. If you choose to sign an authorization to release your PHI, you can later revoke that authorization in writing. This will stop any future release of your health information except as allowed or required by law.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights may have been violated, or you disagree with a decision we may have made about access to your PHI, you may file a complaint with this office. **Please be assured that you will not be penalized and there will be no retaliation for voicing a concern or filing a complaint. We are committed to the delivery of quality health care in an environment that is confidential and private.**

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have questions about this notice or any complaints about our privacy practices, please contact us in writing at:

National Allergy, Asthma & Urticaria Centers of Charleston, P.A.
ATTN: HIPAA Privacy Officer
1879 Savage Road
Charleston, South Carolina 29407

You may also send a written complaint to the Security of the Department of Health and Human Services. The address will be provided at your request.

CHANGE TO THIS NOTICE

We reserve the right to change the terms of this notice at any time. We also reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. The notice will always contain the effective date. This notice went into effect on April 14, 2003.

Organized Healthcare Arrangement

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by National Allergy, Asthma & Urticaria Centers of Charleston, P.A. and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases. I/we am/are aware that the practice of medicine is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have had read to me this consent and understand and agree to its contents.

(Initials)

Authorization for Release of Information and Assignment of Insurance Benefits

My physician is authorized to release any medical information required in the processing of applications or submission information for financial coverage. I/we also agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries – I/we provided all necessary information for proper assignment of Medicare/Medicaid benefits.

(Initials)

Agreement of Financial Responsibility

I/we guarantee payment of all charges associated with services received from National Allergy, Asthma & Urticaria Centers of Charleston, P.A. I/we agree to assign any insurance benefits or other funding to National Allergy, Asthma & Urticaria Centers of Charleston, P.A. I understand it is my responsibility to verify participation status of the physician with my health plan prior to the patient's visit and to obtain a authorization as required by my health plan prior to the patient's visit.

(Initials)

H.I.P.A.A. (Health Insurance Portability and Accountability Act) Notification

I acknowledge my receipt of a copy of the National Allergy, Asthma & Urticaria Centers of Charleston, P.A. Notice of Privacy Practices.

(Initials)

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility can only be revoked upon written notice. By signing below, I/we acknowledge that this consent form has been read in full and explained as necessary.

Date/Time

Signature of Patient (Parent or Legal Guardian)

Signature of Witness

Signature of Guarantor (if different from patient)

PATIENT FINANCIAL POLICY

- We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. We have adapted the following policy to assist you with this necessary aspect of your care.
- Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, we will accept Visa and Mastercard.
- Your insurance policy is a contract between you and your insurance company, the doctor is not involved.
- As a courtesy, we will file your insurance claim for you if you assign the benefits to the physician. In other words, you agree to have your insurance company pay the physician directly. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We can bill those plans for which we have an agreement and can only require you to pay the authorized co-payment at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “*not covered*,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to re-schedule an appointment.
- If you have any questions about the policy, please discuss them with our Practice Manager.
- ***I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.***

Signature of Patient or Responsible Party (if a minor)

Date

Signature of Co-Responsible Responsible Party

Date

Please Print Name of the Patient

PATIENT INFORMATION FORM

Patient _____ Age _____ Sex _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Social Security Number _____

Cell Phone Number _____ E-Mail _____

Could we send newsletters and other information to you from our practice by email? _____

Employed by _____ Address _____

Work Phone _____ Social Security number _____

Spouse (if adult)/Parent (if child) _____ D.O.B. _____ Driver License # _____

SS# _____ Marital Status (if child, parents marital status) _____

Employed By _____ Work Phone Number _____

Referring Doctor _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Method of Payment Cash/Check Visa/Mastercard Card # _____ Exp. Date _____

Signature _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY Effective Date _____

Insurance Company Name _____ Insured _____

Insurance Address _____ City _____ State _____ Zip Code _____

Insurance Phone _____ Insurance D.O.B. _____ Policy # _____ Group # _____

SECONDARY INSURANCE COMPANY Effective Date _____

Insurance Company Name _____ Insured _____
Patient name _____

Insurance Address _____ City _____ State _____ Zip Code _____

Insurance Phone _____ Insurance D.O.B. _____ Policy # _____ Group # _____

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (S) – BACK AND FRONT – AND ANY NEEDED AUTHORIZATION OR REFERRAL FORMS

I authorize the release of any medical information necessary to process any insurance claims. I also authorize payments of medical benefits **NATIONAL ALLERGY, ASTHMA & URTICARIA OF CHARLESTON, P.A.** I understand that I am financially responsible for all charges not covered by my insurance, irrespective of the amount of insurance coverage. I understand that my insurance coverage may not cover all my medical charges, and that I am responsible for any and all billing and/or collection fees.

Date _____ Signature _____

Witness _____

You are scheduled to visit us on _____ at _____ am/pm (circle one) for a complete allergy diagnostic examination. You should be prepared to be at the office at least 2-4 hours. **Take no antihistamines (Please see attached list of medications you need to stop) on the day of the examination and five (5) days before as these may interfere with the tests.**

The physicians and staff of the National, Allergy, Asthma & Urticaria Centers of Charleston are interested in providing excellent care to our patients. To provide that care, we need your cooperation. If you will not be keeping an appointment, we ask that you call our office and allow us to schedule another person in your place. This call should occur at least 48 hours prior to your appointment. Patients who have appointments and do not keep them deprive other patients of appointments or choice of an office location that may be better suited for their needs.

Therefore, we believe that keeping your appointment or a timely cancellation of the appointment of the appointment is an act of common courtesy.

Please obtain the following for your appointment:

1. Recent chest and sinus x-rays/cat scans if taken in the past year.
2. Recent allergy skin testing if done in the past 4 years
3. Recent allergy blood work in the past 4 years

Please complete the following outline and mail it to our office for review immediately. Try to answer the questions to the best of your ability. This information is very important in learning more about your allergy and how to control it.

How did you find about our practice? _____

Briefly state reason for an allergy consultation: _____

SYMPTOMS: Please check if you have any of the following problems:

- Asthma Food Allergy Hay Fever Hives Headaches Heartburn
- Recurrent infections Sinus problems Skin Allergy Reaction to insect Eye Allergies
- Other - Describe _____

PAST HISTORY :

What medical problems do you have? _____

Surgery (type & age when occurred) _____

Major infection or Illnesses (type & age when occurred) _____

Please describe any reactions to medications or latex _____

Have you had your flu vaccine (Please give date) ? _____ Pneumonia vaccine (Please give date)? _____

FAMILY HISTORY: Please list any allergies, asthma, or eczema in parents, brothers, sisters or children.

ENVIRONMENTAL HISTORY

Occupation & Hobbies _____

Do you have exposure to dogs, cats, birds, other animals or feather pillows in the home? Please describe. _____

Do you have carpet in your bedroom? _____ Do you ever sleep with the windows open? _____

Have you had any severe reactions to stinging insects or fire ants? Please describe. _____

Have you had any reactions to foods? Please describe. _____

Have you ever smoked? If so, Type, Amount and Age Begun: _____

Have you quit (Please list year you quit if applicable)? _____ Are you interested in quitting? _____

Who smokes in your household? _____

MEDICATIONS Please list all medications (over the counter, vitamins, herbs) and dosages

PRESCRIPTION LIST

Please contact your prescribing physician before stopping any of the following medications

Certain medications such as antihistamines may interfere with allergy skin testing, which we may perform. Most cough and cold medications contain antihistamines. One tablet, one capsule or one teaspoon of antihistamine may neutralize the skin tests so that they cannot be read properly.

If you need temporary relief of allergy symptoms prior to being tested, Sudafed (not Actifed or Sudafed Plus), Nasalcrom, Phenylephrine, Robitussin DM or Pseudoephedrine can be taken. If you have a fever or are wheezing or pregnant, please let us know because skin testing should not be performed.

Since it is not possible to list all of the antihistamines, please call our office or your pharmacist if you have a question. Products classified as anti-nausea, anti-depressants, tranquilizers, anti-anxiety and motion sickness medications may also contain antihistamines and should not be taken 48 HOURS BEFORE TESTING. PLEASE AVOID THE FOLLOWING MEDICINES FOR 5 DAYS PRIOR TO YOUR APPOINTMENT:

AccuHist Products	Brexin Products	Dalmane	Histaspan Products
Acrivastine	Brocon	Dayquil	Historal Products
Actidil	Bromfed Products	Deconamine	Histex Products
Actifed	Bromfenex Products	Deconomed	Histussin
Alacol	Bromphen Products	Demazin	Hycomine
Alavert	Brompheniramine	Desipramine	Hydroxyzine
Aleve products(some)	Brovex	Desloratadine	Imipramine
Alka-Seltzer	Carbinoxamine	Dexchlorpheniramine	Isophen
Allegra	Cetirizine	Dimetane Products	Klerist
Aller-Chlor products	Chlo-Amine	Dimetapp Products	Kronofed
Aller-Relief	Chlorafed	Diphenhydramine	Librax
Aller-x	Chlordiazepoxide	Disophrol	Limbitrol
Allerest products	Chlordrine	Doxepin	Lodrane
Allerfrim	Clorfed	Dramamine	Loratadine
Allernix	Chloro-Trimeton	Dristan Products	Maxiphen Products
Allrest	Chlorphedrin	Drixoral Products	Maxi-Tuss Products
Ambenyl	Clorpheniramine	Dura-Tap	Meclizine
Amitriptyline	Cimetidine	Duralex	Mesclor
Anamine Products	Citra Products	Elavil	Mirtazapine
Anaplex	Clarinex	Endal HD	Multi-symptom
Antivert	Claritin	Extendryl Products	ND Clear
Aprodine	Clemastine	Famotidine	Naldecon
A.R.M.	Clomipramine	Fedahist Products	Nalex-A
Astelin Nasal Spray	Codeprex	Fedrazil	Napril
Astemizole	Codimal Products	Fexofenadine	Neotep
Atarax	Cohmist Products	Flurazepam	Nizatidine
Atrohist	Comtrex	Formula 44	Nolamine
Atuss Products	Cophene	Genaphed	Nolahist
Axid	Co-Pyronil	Hayfebrol	Norel
Azatadine	Corcidin Products	Hismanal	Nortriptyline
Azelastine	Curaler	Hispril	Novafed
Benadryl	Cyproheptadine	Histabid	Novahistamine
Biohist LA	D-Allergy products	Histafed	Nyquil Products
Bonine	DA Chewable	Histalet	Nytol

Optimine	Remeron	Sudafed-Plus	Tussi-12
Optivar eye drops	Respa Products	Sudafed Sinus/Allergy	Tussionex Products
Orlenta	Respi-Tann Products	Sudal-12	Tylenol Products
Palgic	Restaril	Suphedrine	Vaso-Bid
Pamelor	Rhinex	T-dry	Vicks Products
Pannaz	Rhinosyn Products	Tacaryl Products	Viravan
PBZ Products	Rinade	Tagamet	Vistaril
Periactin	Rondec Products	Tanafed	Xirahist
Pepcid	Ru-Tuss Products	Tavist Products	Zantac
Phenergan Products	Ryna liquid	Teledrin	Zyrtec
Polaramine Products	Rynatan	Temazepam	
Poly-Hist Products	Rynatuss	Theophorin	
Poly-Histine	S-T Forts	Time-Hist	
Polytussin	Seldane	Tofranil	
Promethazine	Semprex	Triacin	
Pyrilamine	Sinarest	Triaminic Products	
QDall	Sinequan	Trinalin	
Quelidnne	Sinovan	Triprolidine	
Ranitidine	Sinulin	Triten	

If you are on a beta blocker drug, ask your prescribing physician if the drug can be omitted the day before and the day of testing. These drugs are usually taken for high blood pressure, migraine headaches, or heart problems. **NO BETA THE DAY BEFORE AND THE DAY OF THE TESTING.** The following are beta blockers:

Acebutol	Coreg	Lopressor	Tenoretic
Atenolol	Corgard	Metipranolol	Tenormin
Betagan	Corzide	Metoprolol	Terazosin HCL
Betapace	Esmolol	Nadolol	Timolide
Betaxolol	Hytrin	Normodyne	Timolol
Betaxon	Inderal	Ocupress	Timoptic
Betimol	Inderide	Optipranolol	Tomoptic
Betoptic	Innopran	Oxprenolol	Trandate
Bisoprolol	Istalol	Penbutolol	Visken
Blocadren	Kerlone	Pindolol	Zebeta
Brevibloc	Labetalol	Propranolol HCL	Ziac
Carteolol	Levator	Sectral	
Cartrol	Levobetaxolol	Slow-Trasicor	
Carvedilol	Levobunolol	Sotalol	

YOU SHOULD CONTINUE THE FOLLOWING MEDICATIONS:

Accolate	Flonase	Orapred	Solumedrol
Advair	Flovent	Oxymetazoline	Spiriva
Aerobid	Foradil	Phenylephrine	Symbicort
Afrin	Guafinesin	Prednisone	Theo-24
Albuterol	Intal	Prednisolone	Theophylline
Alupent	Maxair	Prelone	Tilade
Asmanex	Medrol	Proventil	Uniphyl
Atrovent	Mucinex	Pseudoephedrine	Ventolin
Azmacort	Nasacort	Pulmicort	Xolair
Beconase	Nasal crom	QVAR	Xopenex
Brethaire	Nasalide	Rhinocort	Volmax
Combivent	Nasarel	Serevent	VoSpire
Duoneb	Nasonex	Singulair	Zyflo

Please contact your prescribing physician before stopping any of the previous medications. If you are not sure whether you should stop a medicine and it is not on the previous lists, please contact our office to see if the medicine should be continued or discontinued prior to allergy skin testing.