

ALVERNON ALLERGY & ASTHMA, P.C.

www.alvernonallergy.com

- 2902 E. GRANT ROAD, TUCSON, AZ 85716 • (520) 322-8361
- 6261 N. LA CHOLLA, STE., 101, TUCSON, AZ 85741 • (520) 544-7580
- 9356 E. RITA ROAD, STE. 100, TUCSON, AZ 85747 • (520) 574-3409
- HEATHER CASSELL, MD
- DOUG MIN, MD
- LEONARD SCHULTZ, MD
- GEORGE MAKOL, MD
- KUDAGAL MURTHY, MD

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INIT: _____

SOCIAL SECURITY: _____ DATE OF BIRTH: _____ SEX: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

MARITAL STATUS: _____ EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INIT: _____

RELATIONSHIP TO PATIENT: _____ DAYTIME PHONE: _____ CELL PHONE: _____

PERSON RESPONSIBLE FOR CHARGES - COMPLETE ONLY IF DIFFERENT FROM PATIENT

LAST NAME: _____ FIRST NAME: _____ MIDDLE INIT: _____

RELATIONSHIP TO PATIENT: _____ DAYTIME PHONE: _____ CELL PHONE: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMPLOYER: _____ DAYTIME PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY HOLDER: _____ DOB _____ SOC SEC NO: _____

POLICY NUMBER: _____ GROUP NO: _____

SECONDARY INSURANCE: _____

POLICY HOLDER: _____ DOB _____ SOC SEC NO: _____

POLICY NUMBER: _____ GROUP NO: _____

PLEASE ALLOW US TO PHOTO COPY YOUR INSURANCE CARD(S)

I authorize the Physicians of Alvernon Allergy & Asthma, P.C. to give me or my child reasonable and proper medical care by today's standards and to release medical information, as requested, to my insurance carrier. I realize that these Physicians are not or may not be listed provider(s) with my insurance company; therefore any and all charges incurred are due and payable to the doctor(s). I agree that this office may release medical records pertaining to my treatment to my insurance company or other third party responsible for payment of my medical charges, including reviewing activities related to my physician's participation with my health plan.

SIGNATURE/RESPONSIBLE PARTY: _____ **DATE:** _____

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Please see website for maps

Dear _____,

Your appointment with Doctor _____ has been scheduled for _____
_____. Please check in at _____.

Please bring the following items with you for your appointment:

1. **a complete list of ALL medications, vitamins and supplements you are current taking;**
2. the allergy questionnaire;
3. any allergy solutions and shot records;
4. any medical history that may be useful in your evaluation;
5. **your insurance card, picture ID, a referral (if one is required) and your pharmacy card if you have a separate one.**

Your health care is important to us, but if illness or other circumstances prevent your keeping this appointment, early notification of our *office* allows us to extend the appointment time to other patients. Your cooperation is greatly appreciated.

PREPARATION FOR ALLERGY TESTING

DO NOT TAKE THESE MEDICATIONS FOR 3 DAYS!!!

- Benadryl, diphenhydramine • Chlortrimeton, chlorphenaramine
- Allerest • Extendryl • Bromfed, bromphenaramine
- Other over-the-counter and prescription antihistamine/decongestant medications
- Any type of over-the-counter or prescription cough medicine

DO NOT TAKE THESE MEDICATIONS FOR 5 DAYS!!!

- Allegra, Fexofenadine
- Atarax, Hydroxyzine, Vistaril
- Allerhist-1, Clemastine, Contac, Tavist
- Claritin, Clarinex, Loratadine
- Amitriptyline, Doxepin, Elavil, Sinequan, Tofranil
- Periactin, Cyprohepatadine
- Astelin Nasal Spray
- Zyrtec, Xyzal, Cetirizine
- Optivar or Zaditor eye drops
- Herbal Supplements: Astragalus, Feverfew, Green Tea, Licorice, Milk Thistle, Saw Palmetto, St. John's Wort

The recommended times off these medications are best estimates. Sensitive patients may require longer times. If you are unable to stop these medications, or if there are specific questions about whether to stop any medication, please call our office and ask to speak with one of our nurses.

It is very important that you continue ALL the medications you are currently taking for high blood pressure, heart conditions, fluid pills, circulation, and chronic conditions prescribed by your doctor that are not listed above. You do not need to stop cortisone or prednisone.

THANK YOU!

Your co-pay is to be paid at the time of service

Alvenon Allergy & Asthma P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for an health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable cost-based fee for each page and for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact US using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 2-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: George Makol, M.D.
Telephone: 520-322-8361
Address: 2902 E. Grant Rd.
Tucson, AZ. 85716

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Adult & Pediatric Allergy, Asthma & Immunology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

Name _____

DOB _____

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

Signature _____

Relationship to patient _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
 - Communications barriers prohibited obtaining the acknowledgement.
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (please specify)
-
-

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Heather Cassell, M.D. George J. Makol, M.D. Douglas Min, M.D.
Kudagal Murthy, M.D. Leonard B. Schultz, M.D.

To Our Valued Patients:

Thank you for choosing Alvernon Allergy & Asthma, P.C. for your allergy and asthma needs. Our entire staff is committed to giving all our patients the best service and care. Due to the high demand for appointments, Alvernon Allergy & Asthma, P.C. has implemented a “no show policy”.

MISSED APPOINTMENT & CANCELLATION POLICY

- Alvernon Allergy & Asthma, P.C. will charge a **\$20.00 fee** for all no-shows and cancellations with less than 24 hours notice (without specific medical or personal necessity). This does not include allergy injections as they do not require an appointment.
- The payment of this fee is the responsibility of the patient, NOT of the insurance company.
- Please make note of your appointment date. As a courtesy, our staff will attempt to confirm your appointment 2 days in advance. In the event that we are unable to reach you, it is still your responsibility to keep your appointment.
- Please be sure your information is current, enabling us to contact you.

Thank you for your understanding.

Patient Name – **Print**

Patient Signature

Date

Parent/Guardian Name – **Print**

Parent/Guardian Signature

Date