

Desert Center for Allergy and Chest Diseases

(Please Print)

REFERRING DR. _____ REFERRING DR. PHONE NO. _____

PATIENT NAME: _____
Last Name First Name MI

DATE OF BIRTH: ____/____/____ SS# _____

PERMANENT ADDRESS: _____
City State Zip

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Ins. Co. Name _____

Ins. Co. Name _____

Policy # _____ Grp _____

Policy # _____ Grp _____

Relation to patient _____

Relation to patient _____

Insured's Name _____

Insured's Name _____

Insured's Date of Birth _____

Insured's Date of Birth _____

Insured's SS# _____

Insured's SS# _____

Employer _____

Employer _____

WHO MAY RECEIVE INFORMATION REGARDING YOUR HEALTH INFORMATION?
(CHECK ALL THAT APPLY)

____ Spouse Full Name: _____
____ Children Full Name(s): _____
____ Physician Full Name(s): _____
____ Other Full Name(s): _____

The HIPAA Privacy Rules are available in the provider's office. By my signature, I authorize the above list of persons to receive my Protected Health Information per HIPAA requirements. I may revoke this at anytime by giving written notification to this provider.

Date: _____ Signature _____

Assignment and Release

I, the undersigned, have insurance coverage and assign directly to Desert Center for Allergy and Chest Diseases all medical benefits, if any, otherwise payable for all charges whether or not paid by insurance. I hereby authorize the facility to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

In Medicare assigned cases, the Physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured/Guardian

Date

**DESERT CENTER FOR
ALLERGY AND CHEST DISEASES
NOTICE OF PRIVACY PRACTICES**

To our patients,

This notice will describe how your health information may be used and disclosed, and how you may obtain access of your medical records. This notice referred to as Health Insurance Protection Accountability Act (HIPAA) of 1996.

Our office reserves the right to change this Notice in the future.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are however, permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. We realize that these laws are complicated, but we will attempt to give you an overview of this act. *You may obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.*

Use and disclosure of your health information:

- During the course of your treatment, if the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialists and obtain his/her input.
- If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' compensation.
- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer.
- We may disclose your health information to funeral directors, medical examiners, or coroners, consistent with applicable law to allow them to carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.
- As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people to recalls; to notify a person who may have been exposed to disease or who is at risk for contracting or spreading a disease or condition.
- We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.
- Our office has the right to obtain medical records from other healthcare facilities/providers for continuity of care.
- If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and the health and safety of other individuals.

- To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
- We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
- If we maintain a website that provides information about our office, this Notice will be on the website.
- We may disclose your health information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information has approved their research.

Your health information rights

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- Request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. However, your physician is not required to agree to a restriction that you may have requested. In the event the physician believes it is in the patient's best interest to permit use and disclosure of the protected health information, the protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- Request that you be allowed to inspect and obtain a copy of your medical record and billing record. *You may be required to sign an authorization to obtain this information.*
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request. (We are not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you have questions, would like additional information, want to report a problem regarding the handling of your information or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact Christine Sorensen, Privacy officer. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

Original Effective Date: April 14, 2003

Acknowledgment of Receipt of Privacy Notice
Desert Center for Allergy and Chest Diseases

Original to be maintained in Patient's permanent medical record.

I acknowledge that I have been offered a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed Name

Relationship (Parent, legal guardian,
personal representative, ect.)

DESERT CENTER FOR ALLERGY & CHEST DISEASES – FINANCIAL POLICIES

In order to provide you with proper handling of your charges with our office we ask that you carefully read and then sign the following statement of our financial policy prior to treatment.

It is your responsibility to be aware of your benefits. Exclusion, pre-existing conditions, referrals and terminated benefits may nullify insurance coverage and transfer full responsibility to you, the responsible party. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. All insurance information, including prior authorizations, referrals, and claim forms when necessary, must be provided **at the time of service.** We do not change or re-code our claims once they have been billed to your insurance. This falls into unethical medical office practices.

As a courtesy to our patients, we do file secondary insurance IF the information is provided. If payment is not received within 45 days of billing however, we do ask you to take care of the remaining balance.

This office also has a policy to ask you to update your information to ensure current information at least once a year. It is your responsibility to keep us advised if changes are more frequent.

This office bills **only for services performed by our office.** Any outside services will be billed by the facility performing the procedure and/or laboratory work. You will need to contact them on any billing questions you may have.

Please **read and sign** the following:

1. *I understand that co-pays are due prior to being seen (unless prior arrangements had been made.)*
2. *If my insurance requires referrals or authorization prior to treatment, I take full responsibility to obtain it prior to my visit, or I agree to pay all claims denied to the lack of a proper referral.*
3. *I understand that it is my responsibility to notify the office of any changes to my personal information such as name, address, insurance carrier and/or telephone numbers to properly file my claims.*
4. *In addition, I understand I will be requested at least annually to complete new updates to keep my information current. Failure to properly verify this information will stop my insurance from being billed and I will be responsible for payment in full at the time of service.*
5. *I agree to pay all finance charges, collection cost of 33 1/3%, attorney fees, and any other costs that may arise in order to enforce collection of any outstanding debt in which all other efforts have been exhausted.*
6. *I understand that a 24- hour cancellation notice is REQUIRED in consideration of other patient and to avoid a NO SHOW charge.*
7. *I understand and acknowledge ALL OF THE ABOVE by signing below.*

Printed name of Patient

Signature of Patient/Date

Feel free to speak to our billing department if you have any questions. Thank you for your cooperation

DESERT CENTER FOR ALLERGY AND CHEST DISEASE
3815 E. Bell Rd., #4400
Phoenix, Arizona 85032
602.788.7211

*****NOTICE TO PATIENTS*****

State law requires a physician to notify a patient that the physician has a financial interest in a separate diagnostic facility to which the physician is referring the patient for non-routine services prescribed by the physician, and whether these services are available elsewhere on a competitive basis. We support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, this form advises you that we have a financial interest in the provision of PET scan services provided through the use of the PET scan equipment operated by Scottsdale Medical Imaging, Ltd. Further, the PET scan services that we have prescribed for you are available elsewhere on a competitive basis. If you would like the names and locations of alternative providers, we will be happy to provide them to you.

The law requires us to obtain your written acknowledgement that you have read and understand the disclosures made in this form. Accordingly, please sign and date this form in the space provided below. Your executed form will be kept in your patient file.

Acknowledgement

I have read this Notice to Patients, and I understand the disclosures that it contains.

Dated this _____ day of _____, 20____.

Patient Signature