ADVANCED ASTHMA & ALLERGY OF NNY

19316 US Route 11
Building IV, Suite C
Watertown, NY 13601
Phone: 315-681-4192
Fax: 315-681-4602

PLEASE COMPLETE ALL PAGES IN ITS ENTIRETY WHERE APPLICABLE

PATIENT'S NAME: _____ SEX: M ☐ F ☐
LAST FIRST MIDDLE

DATE OF BIRTH: _____ PATIENT'S SS#: _____ RESIDES WITH: _____

HOME ADDRESS: _____
STREET CITY STATE ZIP

MAILING ADDRESS (if different): _____

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____

PREFERRED FORM OF COMMUNICATION: _____ MARITAL STATUS: _____

RACE:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Declined

ETHNICITY:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined

PRIMARY CARE PHYSICIAN/REFERRING PHYSICIAN

NAME: _____ PHONE: _____

MAILING ADDRESS: _____

PREFERRED PHARMACY

STORE NAME: _____ ADDRESS: _____

PHONE: _____ FAX: _____

In an effort to provide the best possible care we are asking for your permission to access your medication data through the Pharmacy Benefit Manager. ☐ **Approve** ☐ **Do Not Approve**

FAMILY INFORMATION (IF PATIENT IS A MINOR)

Mother/Guardian

NAME: _____

ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

EMPLOYER: _____

SS#: _____ DOB: _____

Father/Guardian

NAME: _____

ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

EMPLOYER: _____

SS#: _____ DOB: _____

EMERGENCY CONTACT

NAME: _____ PHONE: _____ RELATIONSHIP: _____

ADDRESS: _____ DOB: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY NUMBER: _____

HIGH DEDUCTIBLE PLAN: ☐ YES ☐ NO

PAYMENT FOR DEDUCTIBLE PORTION BY: ☐ HSA ☐ EMPLOYER ☐ SELF PAY ☐ OTHER (please specify) _____

POLICY HOLDER: _____ SS# OF POLICY HOLDER: _____ DOB: _____

POLICY HOLDER EMPLOYER: _____

EMPLOYER ADDRESS: _____ PHONE: _____

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER (EXPLAIN): _____

SECONDARY INSURANCE: _____ POLICY NUMBER: _____

POLICY HOLDER: _____ SS# OF POLICY HOLDER: _____

POLICY HOLDER EMPLOYER: _____

EMPLOYER ADDRESS: _____ PHONE: _____

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER (EXPLAIN): _____

PRIVACY STATEMENT ACKNOWLEDGMENT

I acknowledge Advanced Asthma and Allergy of NNY has provided it's Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my health information. If I desire, a copy of the Notice of Privacy Practices is available to me to keep.

_____ _____

Signature of Patient/Parent/Guardian Printed Name of Patient/Parent/Guardian

AUTHORIZATION TO LEAVE MESSAGES

I acknowledge that it is my right to refuse to authorize reminder calls and other types of detailed messages to be left on my voice mail/answering machine and or with family members. This authorization can only be revoked in writing.

☐ Yes, please leave messages Date: _____

☐ No, don't leave any messages Date: _____

FINANCIAL POLICY ACKNOWLEDGMENT

All payments are due at the time of service.

Advanced Asthma and Allergy of NNY has preferred provider contracts with several major insurance companies. **It is your responsibility to contact your insurance company and determine if our practice has a contract with your insurance company.** If our physician is not a participating provider for your plan, you may still select our office for your medical care and "out of network" or self-pay benefits will apply. Our office will not advise you of your insurance benefits. Please contact the Customer Service phone number printed on your insurance card if you have any questions pertaining to your coverage.

If we are unable to file your insurance claim in a timely manner due to invalid or incorrect insurance information which you provided to us, you will be responsible for the charges of the visit. _____ (initial)

Any financial portion that is the "member responsibility" such as a co-pay, co-insurance, and deductible will be collected at the time of service _____ (initial). Remember, your insurance coverage is a contract between you and your insurance company. Advanced Asthma and Allergy of NNY is not responsible for services denied by your insurance company _____ (initial). You will receive a billing statement for any unpaid balances or charge determined not covered under your policy. **A $10.00 monthly billing charge will be added to all accounts over 30 days. Any disputes with balances due must be brought within 30 days of the 1st billing statement or they will not be considered. _____ (initial).**

As a courtesy to our patients, we will file insurance claims from our office. In order to do this we require all information to be completed on the Patient Registration form. We will request an update annually. Please present your insurance card at each appointment. **If you do not provide us with the correct insurance information we will change your account to "Self Pay" and at that point you will be required to make payment within 30 days.**

If you are not insured you will be ask to pay in full at the time of service. You may contact our office to discuss the cost prior to your visit.

We accept cash, personal checks, debit cards, Visa, and MasterCard. Any outstanding balances are due within 30 days of the statement. If you experience circumstances beyond your control, please contact our office and we will be happy to make payment arrangements. All balances reaching 90 days past due will be sent to a collection agency. We realize that temporary financial problems do occur, and we encourage you to contact us promptly for assistance in the management of your account. Payment arrangements may be extended in the event of unusual circumstances.

CHECKS RETURNED TO US BY THE BANK WILL BE ASSESSED AT $20.00 RETURNED CHECK FEE.

WE ARE NOT PARTY TO YOUR DIVORCE/CHILD SUPPORT DECREE. THE RESPONSIBILITY FOR PAYMENT AND THE PRESENTATION OF ACTIVE INSURANCE CARDS AT THE TIME OF SERVICE IS THE RESPONSIBILITY OF THE ACCOMPANYING ADULT.

_____ _____

Patient's (Parent's/Guardian's) Signature Date

APPOINTMENT CANCELLATION/RESCHEDULE/NO-SHOW POLICY

Patient has the right to reschedule an appointment free of charge **one time** by calling our office at least **72 hours** before your scheduled appointment time. If the patient has to reschedule the same appointment again, he/she will be charged a **$50.00 rescheduling fee**. The fee is due at the time of rescheduling the appointment. **In the event an appointment is missed (no-show) or canceled with less than a 72 hour notice, a $50.000 fee will be billed to the patient's account for a Recheck appointment and $150.00 for a New Patient appointment. Insurance companies do not cover missed no-show/cancelled or rescheduled appointments fees. Three (3) consecutive missed/cancelled Recheck appointments, within a 12 month period will result in a patient being discharged from the practice. New Patients with two (2) cancelled/no-show appointment will not be rescheduled.**

I authorize medical care and accept the financial responsibility. I have read and fully understand the financial policies of Advanced Asthma and Allergy of NNY, and agree to the terms.

I authorize the release of any medical or other information necessary to process any claims.

_____ _____

Patient's (Parent's/Guardian's) Signature Date

ADVANCED ASTHMA & ALLERGY OF NNY

Authorization to Release Medical Information

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I hereby give permission to Advanced Asthma and Allergy of NNY to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close friend(s):

Name	Relationship
Name	Relationship
Name	Relationship

The duration of this information is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

OR

_____ Initial if you DO NOT authorize any person(s) to communicate with Advanced Asthma and Allergy of NNY, for any reason.

Patient/Guardian's Signature: _____ Date: _____

ADVANCED ASTHMA & ALLERGY OF NNY

HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Advanced Asthma and Allergy of NNY** to obtain access to my medical records through the health information exchange organization called **HealtheConnections**. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. **HealtheConnections** is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit **HealtheConnections** website at http://healtheconnections.org/.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT for Advanced Asthma and Allergy of NNY** to access ALL of my electronic health information through **HealtheConnections** to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for Advanced Asthma and Allergy of NNY** to access my electronic health information through **HealtheConnections**.

☐ **3. I DENY CONSENT for Advanced Asthma and Allergy of NNY** to access my electronic health information through **HealtheConnections** for any purpose, *even in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in **HealtheConnections** to access my electronic health information through **HealtheConnections**, I may do so by visiting **HealtheConnections** website at http://healtheconnections.org/ or calling **HealtheConnections** at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used only for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through **HealtheConnections**. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from **HealtheConnections**. You can obtain an updated list at any time by checking **HealtheConnections** website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through **HealtheConnections** for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: **(315) 681-4192**; or visit **HealtheConnections** website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following *link:http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as **HealtheConnections** ceases operation. If **HealtheConnections** merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through **HealtheConnections** while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.