Allergy and Asthma
CENTER OF MINNESOTA

PATIENT REGISTRATION

APPOINTMENT DATE: _______________

PATIENT NAME: ________________________________ DOB: _________ MALE/FEMALE
(Last) (First) (Middle)

NICKNAME: __________________

ADDRESS: ____
(City) (State) (Zip)

MARITAL STATUS: Single Married Separated/Divorced Widowed

HOME PHONE: ________________ CELL : ________________ WORK: ________________

E-MAIL: _______________________

Would you like to be included in our quarterly 'Allergy Updates Newsletter? YES NO

Would you like to sign up for our online Patient Portal? YES NO

PRIMARY CARE PHYSICIAN'S NAME: _______________________

CLINIC NAME: ____________________ ADDRESS: _____________________________________

IF YOU WERE REFERRED:

REFERRAL PHYSICIANS NAME: _______________________

CLINIC NAME: ____________________ ADDRESS: _________________________________

Other physician(s) who care for you and to whom we may disclose information regarding your care:

____

EMERGENCY CONTACT: ____
(Name) (Relation) (Phone Number)

IF PATIENT IS A MINOR, PLEASE PROVIDE PARENTAL INFORMATION:

Mother's Name: ________________ DOB: ________________ Phone Number: ________________

Father's Name: ________________ DOB: ________________ Phone Number: _________________

IS YOUR INSURANCE THROUGH AN EMPLOYER? Circle one: YES NO
IF YES, NAME OF EMPLOYER:

____

PRIMARY INSURANCE

IF INCOMPLETE AT TIME OF VISIT, IT IS YOUR RESPONSIBILITY TO CONTACT OUR OFFICE WITHIN 1 BUSINESS DAY TO GIVE COMPLETE AND ACCURATE INFORMATION.

IF NOT DONE SO, PLEASE BE AWARE THAT THE OFFICE VISIT COST MAY NOT BE COVERED AND THE FINANCIALLY RESPONSIBLE PARTY WILL BE ACCOUNTABLE

Insurance Company: __________________Address: ______________________ Effective Date: ___________

Subscriber Name: _____________________ DOB: ________________________

ID# __________________________________ GROUP # _____________________

SECONDARY INSURANCE

Insurance Company: __________________Address: ______________________ Effective Date: ___________

Subscriber Name: _____________________ DOB: ________________________

ID# __________________________________ GROUP # _____________________

INSURED CARDHOLDER OR OTHER FINANCIALLY RESPONSIBLE PARTY

If you, the patient is financially responsible, please only sign your name at the bottom.
If patient is a minor please fill out completely.

I, _____________________________ will assume all financial responsibilities.
(First) (Last)

Address: ____
(City) (State) (Zip)

Cell Phone: ____________________ Home Phone: ______________________

Employer: _____________________ Employer Address: ____

Relation to insured/patient: ____

SIGNATURE OF PATIENT/ PARENT OR GUARDIAN: __________________________**DATE**: ____________

PRACTICE PHILOSOPHY ON PATIENT PRIVACY

Allergy and Asthma Center of Minnesota, PLLC 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.

Revised Effective April 1, 2014

Allergy and Asthma Center of Minnesota ("AACM") 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 AACM 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.**
4. **Appointment Reminders: We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits, or call (or leave you a voicemail) 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:

1. **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.**
2. **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.**
3. **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.**
4. **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 AACM 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 AACM 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 AACM at 612-444-3247. 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. 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: ____

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:

PAYMENT AGREEMENT

Regardless of insurance benefits, or the designation of some other responsible party on the registration form, I understand that I am financially responsible for the fees. I understand I am responsible to know if I am covered by my insurance and if AACM is a provider. If I am covered by Medicare, I understand that if I am provided specific written notice in advance that Medicare is not likely to cover a particular visit or procedure, I will be responsible for payment of that procedure or visit if I agree to proceed. Although AACM will take reasonable steps to obtain reimbursement from the insurance company or the persons listed on the registration form as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financially responsible party. Further, in the event of payment default, I agree to pay all collection costs in excess of the initial fee (including any legal expenses) and, at the option of AACM, a reasonable charge for late payments. I also understand that if a payment made by check is returned, there will be a **$30** fee added to my account.

AT THE TIME OF THE VISIT, I understand it is my responsibility to obtain a current referral (if required) and pay any **deductibles, co-payments,** and/or **coinsurance** not covered by the insurance plan or a government program. Further, I authorize AACM to file claims on my behalf for covered services and assign all insurance or other payer benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original. For more than two missed appointments, there is a **$20** fee at check-in to be seen again unless the appointments have been cancelled at least 24 hours in advance.

I have read and I understand this document.

Patient/Parent/Guardian Signature: ______________________________Date: ____________

Patient Consent for Use and Disclosure of Medical Information To Carry Out Treatment, Payment, and Health Care Operations

I consent to the release of information regarding services rendered by AACM to my insurance company or any governmental payer of the medical expenses as listed above, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of all medical information (including - but not limiting – doctor's notes, labs, pictures of ailments, etc.) to my family physician and other treating physicians/laboratories, as listed by me above, as well as to any physicians to whom AACM may refer me for purposes of further treatment/diagnosis. I consent to the use and/or release of medical information about me for purposes of health care operations, as it relates to AACM's internal practices and general administrative activities. In addition, if the patient is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person (s) that I have listed above as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including, but not limited to, electronic mail ("email") and facsimile.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that AACM has taken action in reliance upon my consent.

Patient/Parent/Guardian Signature: ______________________________ Date: _______________