Asthma & Allergy Associates P.C.

Elliot Rubinstein, M.D. Mariah Pieretti, M.D. Rizwan Khan, M.D. Joseph Flanagan, M.D. Stella Castro, M.D. Julie McNairn, M.D.

Patient Information

Patient Name:____ Date of Birth:_____/_____/_____

Mailing Address: ______________________________________ Social Security No.:_____/_____/_____

City:____________________State:_____Zip:________ Referred By:__________________________

Home Phone:_____/_____/_____ Fax:_____/_____/_____ Family Physician:______________________

Cell:_____/_____/_____ Work Phone:_____/_____/_____ Ext:_____ Occupation:__________________

Employer:________________________________ Emergency Phone:_____/_____/_____

Emergency Contact Name/Relationship:____

Pharmacy Used for Prescriptions:__________________________________ Marital Status: S M D W

Sex: M F Smoker: Y N Full-time Student: Y N Email:___________________________________

Place of Residence: House Apartment Nursing Home School Other:________________________

How did you hear about us? Patient Doctor Ins. Co. Newspaper Phone Book Web Search Other:____________

The person who is responsible for my bills and/or carries my insurance coverage

Name:____ Relationship to Patient:______________________

Mailing Address: : ______________________________________ Date of Birth:_____/_____/_____

City:____________________State:_____Zip:________ Social Security No.:_____/_____/_____

Home Phone:_____/_____/_____ Fax:_____/_____/_____ Employer:__________________________

Cell:_____/_____/_____ Work Phone:_____/_____/_____ Ext:_____ Occupation:__________________

Date of Birth:_____/_____/_____ Social Security No.:_____/_____/_____ Sex: M F

Marital Status: S M D W Email:____________________________________

Insurance Information

Insurance Company:______________________________ Policyholder's Name:_________________________

Relationship to Patient:___________________________ Policy No.:_____________Group No.:___________

Effective Date of Primary Insurance:____/____/____ Effective date of Secondary Insurance:____/____/____

Secondary Insurance:_____________________________ Policyholder's Name:________________________

Relationship to Patient:___________________________ Policy No.:_____________Group No.:___________

Primary Care Physician (as states on insurance card):____

I certify that the information given by me in applying for payment under my insurance carrier(s) is correct. I authorized any holder of medical/insurance information about me to release to my physician/insurance(s) any information required to process my claims. I understand that to knowingly withhold insurance reimbursement payments for medical services rendered would be committing a wrongful act. I request that reimbursement from my insurance(s) be made payable to the physician's office that has rendered service to me. I attest that the information I have given on these forms is true and correct to the best of my knowledge..

____ Date:_____/_____/_____

Signature

We are a fragrance-free office • Please bring your insurance card(s), picture ID, and co-pay

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Cortland Elmira Ithaca Vestal Fayetteville

NOTICE OF PROTECTED HEALTH INFORMATION 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.

As part of the healthcare service you receive from Asthma & Allergy Associates P.C., health records are generated and maintained describing your care, including but not limited to: your name, address, phone number, social security number, health history, symptoms, examination and test results, diagnoses, procedures, treatment, and plans for future care or treatment. This information is called "Protected Health Information."

This Notice of Privacy Practices describes how Asthma & Allergy Associates P.C. may use and disclose your information, and the rights that you have regarding your health information.

Uses and Disclosures of Health Information Without Authorization

When you obtain services from Asthma & Allergy Associates P.C., certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment. For example: Disclosure of medical information about you may be made to doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories, or radiology centers for the coordination of different treatments.

Your health information will be used for payment. For example: Health information about you may be disclosed so that the services provided to you may be billed to an insurance company or a third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.

Your health information will be used for healthcare operations. For example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

Business associates. There are some services that we provide through contracts with third party business associates. Examples include external laboratories, transcription agencies, copying services, and clinical research studies. To protect your health information, Asthma & Allergy Associates P.C. will require these business associates to properly protect your information.

Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse, or responding to court orders;

For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to foods, medications, or devices;

For health oversight activities such as audits, inspections, or licensure investigations;

To organ procurement organizations for the purpose of tissue donation and transplant;

For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information;

To coroners and funeral directors for the purposes of identification, determination of the cause of death, or to perform their duties as authorized by law;

To avoid a serious threat to the health or safety of a person or the public;

For specific government functions, such as the protection of the President of the United States;

For Workers' Compensation purposes;

To military command authorities as required for members of the armed forces;

To authorized federal officials for national security and intelligence activities as authorized by law;

To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by law.

Other Allowable Uses and Disclosures Without Authorization: Other uses or disclosures of your health information that may be made include:

Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives;

Notifying you of health-related benefits and services that may be of interest to you;

Notifying you of clinical research studies that may be of interest to you.

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

YOUR INDIVIDUAL RIGHTS UNDER HIPAA

1. You have the right to request restrictions on certain uses and disclosures of your Protected Health Information. For example, you may wish to restrict your employer from knowing about a medical condition. Regardless of your request, please know that the HIPAA rules allow our office to share your Protected Health Information with the Covered Entities.
2. You have the right to receive your Protected Health Information in a confidential communication from our office, such as the U.S. Mail.
3. You have the right to inspect and copy your Protected Health Information. Copies of your Protected Health Information are available for a reasonable fee paid to our office to cover our expenses for reproducing them.
4. You have the right to request that we amend your Protected Health Information. In some cases, we may require these requests to be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address and phone number listings.
5. You have the right to receive, upon request, an accounting of your Protected Health Information that we have provided to Non-Covered Entities.
6. If you have read and responded to this notice through electronic media such as our practice website or e-mail, you have the right to receive a paper copy of this notice upon request. If you would like to exercise any of these rights, please contact the HIPAA Compliance Department in our office at (607) 257-6563, and we will make the necessary arrangements for you.

Asthma & Allergy Associates P.C. is required by law to maintain the privacy of your Protected Health Information and to provide you with this notice of our legal duties and privacy practices as they apply to your Protected Health Information. We are also required to abide by the terms of this notice, which are currently in effect.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for all of the Protected Health Information that we maintain. In the event we elect to change the terms of this notice, a new notice will be posted in our office and on our practice website. In addition, you may receive notification by direct mail or other such communications our practice may implement from time to time.

Should you ever believe that your privacy rights have been violated, we request that you file a complaint with our office by contacting our HIPAA Compliance Department at (607) 257-6563. You may also register your complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy. Any complaint you file will be used strictly to improve our operating procedures, and in no way will you be retaliated against for filing a complaint.

Should you have any questions or concerns, please contact our HIPAA Compliance Department at (607) 257-6563.

CAP CLINICAL INTEGRATION

Asthma & Allergy Associates P.C. is part of the Cayuga Area Preferred ("CAP") Clinical Integration Program. This allows all health care providers participating in the CAP Program to have access to and share data in your medical records in order to provide care to you and for the purposes of improving the quality of care in the community. You can call CAP for details about the program at (607) 274-4616, or visit their website at www.cayugaareaphysiciansalliance.org

Asthma & Allergy Associates P.C., along with other providers participating in the program, are able to access Protected Health Information (PHI) about you collected from all places where you receive health care and from insurance companies that pay for your health care. The collected information is only to be used in connection with providing care to you and for the purposes of improving the quality of care in the community, and is only open to providers and their staff participating in the CAP program. You may decide whether or not to allow CAP participating providers and their staff members to access your protected health information. Your choice to give or deny consent will not affect your ability to get medical care or health insurance coverage and will not be the basis for denial of health services.

I understand that, by signing this form, I have received a more complete description of the uses and disclosures of PHI and CAP. I give consent to how PHI is used/disclosed to carry out treatment, payment or healthcare operations, and for purposes of providing care within the network of providers participating in the CAP Clinical Integration Program and their staff, accessing all of my PHI through the CAP database. I understand that I am responsible for complying with the policies and procedures of PHI, and that I am required to seek guidance from the Practice's Privacy Officer if I have questions or concerns regarding PHI or the CAP program.

My signature below certifies that I have read and understand the above terms and conditions of this notice.

____ ____
Patient/Legal Representative Signature   Name of Legal Representative

______________________________ ____/____/____ ____
Printed Name   Date   Relationship to Patient

Protected Health CAP Clinical Integration Consent Form

Patient Name: **DOB:** **Age:** **Acct. #:**

☐ Patient reviewed HIPAA/Clinical Integration Privacy Statement

☐ Privacy Alert

Mobile Text/Cell: ( ) **Home Phone:** ( ) **Work Phone:** ( )

Email: **Other:**

Patient Preference/Appointment Information

______ ☐ Home Phone (Include Auto Call)?

______ ☐ Mobile Text (Include Auto Call)?

☐ Mobile Text (Include Auto Text)?

______ ☐ Work Phone?

☐ With Another Person Answering the Phone?

☐ Send via Mail?

☐ Send via Email?

Patient Preference/Medical Information

______ ☐ Home Phone (Include Auto Call)?

______ ☐ Mobile Text (Include Auto Call)?

☐ Mobile Text (Include Auto Text)?

______ ☐ Work Phone?

☐ With Another Person Answering the Phone?

☐ Send via Mail?

☐ Send via Email?

Individual(s) and their relationship to me, whom I authorize you to communicate with regarding my health care (in an emergency, other than, or in addition to, parent/legal guardian signing this authorization):

Name: **Relationship to Patient:** **Emergency Phone Number:**

Name: **Relationship to Patient:** **Emergency Phone Number:**

____

Patient/Legal Representative Signature

Printed Name of Above Signature if Legal Representative:

Relationship to Patient:

Date: **Expiration Date of Consent:**