How to Prepare for Your First Appointment

1. Please bring your insurance card(s), photo ID and all new patient paperwork. Please ensure all paperwork is filled-out completely prior to your arrival. Please check-in at least 15 minutes prior to your scheduled time to allow our Patient Care Coordinators at the front desk to check you into the system.

2. Bring all medication bottles of drugs you are currently taking. This includes any over-the-counter, herbal and as-needed medications. By bringing in the actual prescription bottles, we will be able to accurately record your dose and all other pertinent information we need for your medical chart.

3. Bring a list of any medication and food allergies that you may have and a description of the type of reaction you had to the medication and/or food.

4. Bring your Primary Care Provider’s contact information and your past medical history. If available, please bring in any medical records from previous medical appointments. This information will be very helpful in performing a comprehensive evaluation.

5. Please allow approximately 1.5 hours for your first appointment. If you have any questions regarding any of these instructions, please do not hesitate to call us for clarification.

TESTING FOR ASTHMA: Sometimes we perform lung function testing in which you breathe into a handheld device connected to a computer. This determines whether or not you have asthma. This test also determines how well your asthma is controlled with the current medications you are taking.
PATIENT REGISTRATION

Today’s Date:__________________________

Patient’s Name: ___________________________ DOB: _______ Sex:__________

Mailing Address: ____________________________________________________________

City/State: ___________________________ Zip code__________ SS#: ____________

Email: ___________________________ Phone#: ___________________________

Occupation: ________________________________________________Work Phone#: ___________________________

Responsible Party: ___________ DOB: _______ Relationship: ______________

Mailing Address: ____________________________________________________________

City/State: ___________________________ Zip code__________ SS#: ____________

Email: ___________________________ Phone#: ___________________________

Occupation: ________________________________________________Work Phone#: ___________________________

Primary Insurance: ______________________________ Secondary Insurance: ______________________________

Ins. Address: ___________________________________________ Ins. Address: ____________

Insured’s Name: ___________________________________________ Insured’s Name: ___________________________

Insured’s DOB: ___________________________ Insured’s DOB: ___________________________

ID#: ___________________________ ID#: ___________________________

Group#: ___________________________ Group#: ___________________________

Employer: ___________________________________________ Employer: ___________________________

Effective Date: ___________________________ Effective Date: ___________________________

Emergency Contact: ___________________________ Relationship: ___________________________

Primary Phone: ___________________________ Secondary Phone: ___________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Columbia Asthma & Allergy Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature: ___________________________________________ Date: ___________________________
REFERRING PHYSICIAN INFORMATION FORM

Were you referred to CAAC by another provider? □ Yes □ No

Referring Provider/Clinic: ____________________________________________
Provider Address: ___________________________________________________
Physician Phone: _____________________________ Physician Fax: _______________________
Type of Physician: ___________________________________________________

As a courtesy to other providers working on your medical team and to assist with continuity of care, CAAC is happy to send a copy of your medical records to any physician you specify. Please list them below:

Primary Care Provider/Clinic: ____________________________________________
Provider Address: ___________________________________________________
Physician Phone: _____________________________ Physician Fax: _______________________
Type of Physician: ___________________________________________________

Provider/Clinic: ___________________________________________________
Provider Address: ___________________________________________________
Physician Phone: _____________________________ Physician Fax: _______________________
Type of Physician: ___________________________________________________

Provider/Clinic: ___________________________________________________
Provider Address: ___________________________________________________
Physician Phone: _____________________________ Physician Fax: _______________________
Type of Physician: ___________________________________________________

By signing this document, I authorize CAAC and its providers to release my medical records to the above named physicians. I may revoke this authorization at any time in writing.

Patient/Guardian Signature: __________________________________________ Date: ________________________

www.columbiaallergy.com
New Patient History Questionnaire

Date of Visit:__________________    Primary Provider:__________________
Patient Name:__________________    DOB:____________    Gender:______

How did you hear about our clinic?
☐ Advertisement (please specify): ________________________________
☐ Social Media (please specify): ________________________________
☐ Friend/ current patient: ________________________________
☐ Referring physician: ________________________________
☐ Other: ________________________________

Briefly state what symptoms are bringing you here:
________________________________________________________________________________
________________________________________________________________________________

Have you ever seen a specialist (allergist, dermatologist, ENT, pulmonologist) for allergy-related problems?  ☐ yes    ☐ no
If yes, who? __________________________________________________________

<table>
<thead>
<tr>
<th>Environmental Allergy Symptoms (Check all that apply)</th>
<th>If none, check here: ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nose / Sinuses / Throat</strong></td>
<td></td>
</tr>
<tr>
<td>☐ sneezing</td>
<td></td>
</tr>
<tr>
<td>☐ itching nose</td>
<td></td>
</tr>
<tr>
<td>☐ congestion / stuffiness</td>
<td></td>
</tr>
<tr>
<td>☐ runny nose (☐ clear ☐ colored)</td>
<td></td>
</tr>
<tr>
<td>☐ nose bleeds</td>
<td></td>
</tr>
<tr>
<td>☐ snoring</td>
<td></td>
</tr>
<tr>
<td>☐ loss of smell</td>
<td></td>
</tr>
<tr>
<td>☐ nasal polyps</td>
<td></td>
</tr>
<tr>
<td>☐ history of deviated septum</td>
<td></td>
</tr>
<tr>
<td>☐ post nasal drip</td>
<td></td>
</tr>
<tr>
<td>☐ scratchy throat</td>
<td></td>
</tr>
<tr>
<td>☐ dry throat</td>
<td></td>
</tr>
<tr>
<td>☐ sore throat</td>
<td></td>
</tr>
<tr>
<td>☐ constantly clearing throat</td>
<td></td>
</tr>
<tr>
<td>☐ headache</td>
<td></td>
</tr>
<tr>
<td>☐ sinus pressure / pain</td>
<td></td>
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<tr>
<td>☐ frequent sinus infections (# per year__________)</td>
<td></td>
</tr>
<tr>
<td>☐ Nasal / Sinus Procedures (circle):</td>
<td></td>
</tr>
<tr>
<td>☐ surgery, sinus x-ray, sinus CT</td>
<td></td>
</tr>
<tr>
<td>Date(s):_____________________________________________</td>
<td></td>
</tr>
<tr>
<td><strong>Eyes</strong></td>
<td></td>
</tr>
<tr>
<td>☐ itchy</td>
<td></td>
</tr>
<tr>
<td>☐ watery</td>
<td></td>
</tr>
<tr>
<td>☐ redness</td>
<td></td>
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<tr>
<td>☐ eyelids swollen</td>
<td></td>
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<tr>
<td>☐ sensitive to light</td>
<td></td>
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<tr>
<td>☐ blurred vision</td>
<td></td>
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<tr>
<td><strong>Ears</strong></td>
<td></td>
</tr>
<tr>
<td>☐ itching</td>
<td></td>
</tr>
<tr>
<td>☐ plugging</td>
<td></td>
</tr>
<tr>
<td>☐ discharge</td>
<td></td>
</tr>
<tr>
<td>☐ aching/pain</td>
<td></td>
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<tr>
<td>☐ hearing loss</td>
<td></td>
</tr>
<tr>
<td>☐ recurrent ear infections</td>
<td></td>
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<tr>
<td><strong>Previous Allergy Testing/Treatment</strong></td>
<td></td>
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<tr>
<td>☐ Allergist evaluation</td>
<td></td>
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<tr>
<td>(Date:__________)</td>
<td></td>
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<tr>
<td>☐ ENT evaluation (Date:__________)</td>
<td></td>
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<tr>
<td>☐ skin testing (Last Date:__________)</td>
<td></td>
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<tr>
<td>☐ blood testing (Last Date:__________)</td>
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<tr>
<td>☐ allergy shots (for ____ years and stopped in _______ (year)</td>
<td></td>
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<tr>
<td><strong>Symptoms are aggravated by:</strong></td>
<td></td>
</tr>
<tr>
<td>☐ tobacco smoke</td>
<td></td>
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<tr>
<td>☐ exercise</td>
<td></td>
</tr>
<tr>
<td>☐ cold air</td>
<td></td>
</tr>
<tr>
<td>☐ animals</td>
<td></td>
</tr>
<tr>
<td>☐ workplace or school</td>
<td></td>
</tr>
<tr>
<td>☐ dusting or vacuuming</td>
<td></td>
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<tr>
<td>☐ odors or scents</td>
<td></td>
</tr>
<tr>
<td>☐ yard work</td>
<td></td>
</tr>
<tr>
<td>☐ weather change</td>
<td></td>
</tr>
<tr>
<td>☐ being outdoors</td>
<td></td>
</tr>
<tr>
<td>☐ aspirin / related medications</td>
<td></td>
</tr>
<tr>
<td>☐ other: ______________________</td>
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</tr>
</tbody>
</table>

| **Symptoms first began:**                               |                         |
| ☐ childhood at age _____                                |                         |
| ☐ adult at age _____                                    |                         |

| **Symptoms occur in:**                                  |                         |
| ☐ spring                                                | ☐ summer                |
| ☐ fall                                                  | ☐ winter                |

| **Symptoms interfere with:**                            |                         |
| ☐ sleep                                                  | ☐ work/school            |
| ☐ recreation                                             |                         |
## Current Medications (Prescription, Over-the-Counter, Vitamins, Supplements, etc.)

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength / Dose / Frequency</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Previous Medications Tried: ____________________________________________________________

## Medication / Drug Allergies

<table>
<thead>
<tr>
<th>Drug/Medication Name</th>
<th>Description of Reaction</th>
<th>Reaction Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

If No Drug Allergies, check here: ❑

## Asthma / Respiratory Problems (Check all that apply)

- Asthma diagnosed in year ______
- Asthma NOT diagnosed, but:
  - frequent bronchitis/croup
  - respiratory troubles as a child
  - inhalers like albuterol help
  - steroid medicine helps
- COPD/emphysema diagnosis (year____)
- cough
  - dry
  - wet / mucus
  - clear, yellow/green,
- bloody
- chest tightness
- chest pain
- shortness of breath
- wheezing
- lips and/or fingernails turn blue

Symptoms first began:
- Age: ________

<table>
<thead>
<tr>
<th>Previous Testing/Treatment</th>
<th>Symptoms are aggravated by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonologist evaluation</td>
<td>tobacco smoke</td>
</tr>
<tr>
<td>Last Date:_________________</td>
<td>exercise</td>
</tr>
<tr>
<td>Pulmonary function testing</td>
<td>cold air</td>
</tr>
<tr>
<td>Date(s):__________________</td>
<td>animals</td>
</tr>
<tr>
<td>Chest x-ray</td>
<td>workplace or school</td>
</tr>
<tr>
<td>Date(s):__________________</td>
<td>dusting or vacuuming</td>
</tr>
<tr>
<td>ER visits</td>
<td>odors or scents</td>
</tr>
<tr>
<td>How many?_______</td>
<td>yard work</td>
</tr>
<tr>
<td>Last visit:_______________</td>
<td>weather change</td>
</tr>
<tr>
<td>Hospitalized ______ times</td>
<td>being outdoors</td>
</tr>
<tr>
<td>Last hospitalization:______</td>
<td>aspirin / related medications</td>
</tr>
<tr>
<td></td>
<td>other: ____________________</td>
</tr>
</tbody>
</table>

Symptoms are aggravated by:
- tobacco smoke
- exercise
- cold air
- animals
- workplace or school
- dusting or vacuuming
- odors or scents
- yard work
- weather change
- being outdoors
- aspirin / related medications
- other: ____________________

Symptoms occur in:
- spring
- summer
- fall
- winter

Symptoms interfere with:
- sleep
- work/school
- recreation
## Skin Problems

**(Check all that apply)**

- itching
- dry, scaly skin
- eczema
- welts, hives
- rash
- skin swelling
- recurrent skin infections

**Location of skin problems:**

<table>
<thead>
<tr>
<th>Symptoms first began:</th>
<th>If none, check here:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ childhood at age _____</td>
<td></td>
</tr>
<tr>
<td>■ adult at age _____</td>
<td></td>
</tr>
</tbody>
</table>

**Symptoms are made worse by:**

- 
- 
- 

**Previous Testing/Treatment**

- Dermatologist evaluation
  - Last Date:
- medications (see medication list)
- moisturizers
- other:

**Symptoms interfere with:**

- sleep
- work/school
- recreation

## Food Allergies

**If No Food Allergies, check here:**

- Previous food allergy testing?
  - yes (If yes, skin test    
  - blood test
  - Date(s):

**Food(s) Causing Reaction:**

<table>
<thead>
<tr>
<th>Description of Reaction:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

**Reaction Date:**

- 
- 
- 

## Latex, Insect Stings, Chemicals, and Other Allergic Reactions

**If No Other Allergies, check here:**

- Item Causing Reaction:

<table>
<thead>
<tr>
<th>Description of Reaction:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

**Reaction Date:**

- 
- 
- 

## Other Past Medical History

**Immunizations:**

- up to date
- not up to date

- Have you received: 1) Flu vaccine in past year: yes    no
- 2) Pneumonia vaccine: yes in _____(year)    no

**Surgeries / Hospitalizations**

(details and date):

- 

**Other Medical Conditions:**

- None

- Diabetes
- Seizures
- Heart Disease
- High Blood Pressure
- GERD
- Thyroid Disease
- Kidney Disease
- Liver Disease
- Other Lung Diseases
- Other

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### Family History

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Brother(s)</th>
<th>Sister(s)</th>
<th>Child(ren)</th>
<th>Grandparent(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hayfever / Allergies:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Sinus Trouble:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Asthma:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Frequent Bronchitis:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Eczema:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Hives:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Migraine Headaches:</td>
<td>❑</td>
<td>❑</td>
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<td>❑</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Thyroid Disease:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Food Allergies:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Other:</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

**Autimmune Disease (in any relatives):**

---

### Social History

Occupation: _____________________________________________

Recent Travel History: _____________________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced/Sep. ❑ Widowed

Exercise: _______________________________________________

Hobbies: _______________________________________________

Special Diet?: ___________________________________________

Current smoker? ❑ no ❑ yes, ___ packs per day

Past smoker? ❑ no ❑ yes, ___ packs per day for ___ years. Quit in ______.

Alcohol Use: ❑ None ❑ 1-5 drinks per week ❑ More than 5 drinks per week

Recreational Drug Use (confidential): ❑ yes ❑ no

---

### Environmental History

**Primary residence:** ❑ House ❑ Apartment/Condo/Townhouse ❑ Mobile Home

Location: ❑ city/suburban ❑ rural

Residence is ____ years old and have lived there for ___ years.

Previously lived in (city/state/country):________________________

Does your home have a basement? ❑ no ❑ yes

(if yes, ❑ finished ❑ unfinished ❑ dry ❑ damp ❑ musty)

History of water damage in home? ❑ no ❑ yes

Is there mold visible in the home? ❑ no ❑ yes

Smokers in the home? ❑ no ❑ yes

Pets: ___ dog(s) ___ cat(s) Other:__________________________

❑ indoor ❑ outdoor ❑ allowed in bedroom

**Heating:** ❑ central ❑ electric ❑ gas ❑ radiator

❑ wood fireplace ❑ gas fireplace

**Air Conditioning:** ❑ central ❑ in-window ❑ fans

**Filter System:** ❑ yes ❑ no

**Humidifier:** ❑ yes ❑ no

**Flooring:**

In main areas: ❑ carpet ❑ laminate

❑ hardwood

In bedroom: ❑ carpet ❑ laminate

❑ hardwood

**Bed:** ❑ mattress/boxspring ❑ latex ❑ foam

❑ waterbed ❑ other ______

(Allergy encasement? ❑ yes ❑ no)

**Pillows:** ❑ feather ❑ non-feather

(Allergy encasements? ❑ yes ❑ no)

---

**Pharmacy/Address:** _________________________________

Phone #: __________________________

Fax #: __________________________

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please read carefully.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI):
This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and controls your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future health or condition and related health care services.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

FOR TREATMENT: We will use health information about you to furnish services and supplies to you, in accordance with our policies and procedures.

FOR PAYMENT: We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. In addition, certain information may be released to a collection agency, if necessary, to collect payment from you.

FOR HEALTH CARE OPERATIONS: We may use and disclose information about you for the general operation of our business: Accreditation organizations, auditors or other consultants, for example. We may disclose protected health information about you in connection with certain public health reporting activities. We may disclose such information to a public health authority authorized to collect or receive PHI, for example, State health departments, Center for Disease Control, and the Food and Drug Administration to name a few. We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect, domestic or elder abuse. Additionally, we may disclose PHI to a person subject to the Food and Drug Administration’s power for the following activities: to report adverse events, product defects or problems, or biological product deviations, to track products, to enable product recalls, repairs or replacements, or to conduct post-marketing surveillance.

We may disclose PHI in connection with certain health oversight activities of licensing and other agencies. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, 4) entities subject to civil rights laws for which health information is necessary for determining compliance. We may disclose information in response to a warrant, subpoena, or other order of a court or administrative hearing body, and in connection with certain government investigations and law enforcement activities. If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials. Workers Compensation Programs. We may release your PHI to workers’ compensation or similar programs. Avoid Harm. PHI will be disclosed if necessary to prevent a serious threat to the health and safety of you or others. Research Purposes. We may use or disclose certain PHI about your condition and treatment for research purposes where and Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment. Please note that no medical information or personal
health information will be left on a recorder, voice mail or discussed with anyone other than you unless given permission in writing.

Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you. Individuals Involved in Your Care or Payment For Your Care. We may disclose information to individuals involved in your care or in the payment for your care, but we will obtain your agreement before doing so. This includes people and organizations that are part of your “circle of care”—such as your spouse, your other doctors, or an aide who may be providing services to you. Although we must be able to speak with your other physicians or health care providers, you can let us know if we should not speak with other individuals, such as your spouse or family members. We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization. We will be unable to take back any disclosures already made based upon your original permission.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI:
The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask for restrictions on the uses and disclosures of your PHI beyond those imposed by law. We will consider your request, but we are not required to accept it. The Right to Choose How We Send PHI to You. You have the right to request that you receive communications containing your PHI from us by alternative means or locations, i.e. Email The Right to See and Get Copies of Your PHI. Except under certain circumstances, you have the right to inspect and copy medical and billing records about you. We may charge you a fee for copying and mailing. The Right to Get a List of the Disclosures We Have Made. You have a right to ask for a list of instances when we have used or disclosed your medical information for reasons other than your treatment, payment for services furnished to you, our healthcare operations, or disclosures you give us the authorization to make. If you ask for this information from us more than once every twelve months, we may charge you a fee.

IV. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES:
If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your PHI, you may file a complaint with Dr. Sanjeev Jain, owner of Columbia Asthma & Allergy Clinic. Please request the grievance form from the receptionist or the business office manager. On completion of this form it will be given directly to Dr. Jain and the Compliance Committee for their immediate review and resolution. The Compliance Committee consists of the clinic staff. You may also send a written complaint to the Sec. of the Dept of Health and Human Service at 200 Independence Ave, SW, Room 509F, HHH Bldg., Washington, DC 20201. This clinic will not take any retaliatory action against you for filing a complaint about our privacy practices.

If you have any questions about this notice or any complaints about our privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Columbia Asthma & Allergy Clinic, Attention: Compliance Officer, 1406 SE 164th Ave, Suite 250, Vancouver, WA 98683 | (360)-834-6700.

I, _________________________________________________________________, have received and/or read a copy of Columbia Asthma & Allergy Clinic Notice of Privacy Policies.

__________________________
Signature

__________________________
Date

You have the right to a copy of this notice in paper form. You may ask us for a copy at any time.
AUTHORIZATION & CONSENT OF PARENT OR LEGAL GUARDIAN
(Please complete if the patient is a minor or if Power of Attorney applies)

Patient Name: _____________________________  DOB: ______________________

Under the requirements of HIPAA we are not allowed to release medical and/or billing information (with some specific exceptions) without the parent or legal guardian’s consent. If you wish to have your child’s medical and/or billing information released, please complete and sign this form.

I authorize Columbia Asthma & Allergy Clinic to release my child’s medical information to the following individual(s):

1. __________________________________      Relation to Patient: __________
2. __________________________________      Relation to Patient: __________

I authorize Columbia Asthma & Allergy Clinic to release my child’s medical billing information to the following individual(s):

1. __________________________________      Relation to Patient: __________
2. __________________________________      Relation to Patient: __________

School/Daycare Name: ______________________________________________________
Address: ________________________________________________________________
Phone Number: _________________________  Fax Number: ________________
Information Authorized to Disclose: (circle):  Medical  Billing  Medical & Billing

Parent/Legal Guardian
I understand I have the right to revoke this authorization, in writing, at any time and that I have the right to inspect of copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by Federal or State law that may be subject to redisclosure by the above recipient.

Parent/Legal Guardian Signature: ________________________________    Date: __________
Printed Name: ________________________________________________

Updated 11/2018 JBS
AUTHORIZATION FOR RELEASE OF INFORMATION FOR ADULTS

Patient Name: _____________________________  DOB: ______________________

Many of our patients allow family members such as their spouse, parents, children or other loved ones to call and request medical and/or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone (with some specific exceptions) without the patient’s consent. If you wish to have your medical and/or billing information released to someone else, please fill-out this form in its entirety.

I authorize Columbia Asthma & Allergy Clinic to release my medical and/or billing information to the following individual(s):

1. _______________________________  Relation: _____________
2. _______________________________  Relation: _____________
3. _______________________________  Relation: _____________

Patient Information

I understand I have the right to revoke this authorization, in writing, at any time and that I have a right to inspect or copy my protected health information (PHI) to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by Federal or State law and may be subject to redisclosure by the above recipient.

Signature: _______________________________  Date: _____________
Printed Name: _______________________________
Consent for Electronic Communication

This consent form gives Columbia Asthma & Allergy Clinic permission to use the contact information provided below to send reminders regarding upcoming appointments. Contact information may also be used in the case of clinic closure, weather delays or to update patients on any unforeseen circumstances which may interfere with their appointment. Correspondence may come in the form of a phone call, text message or email. Columbia Asthma & Allergy will not disclose or release any of this contact information without explicit written permission.

Phone number: _____________________   Text message O.K.? □ YES   □ NO

Cost for text messaging may apply per your agreement with your individual cellular carrier. Columbia Asthma & Allergy Clinic is not responsible for any fees associated with this communication

Email address: ____________________________________________________

Preferred form of contact:   □Email   □Phone   □Text Messaging

I hereby authorize Columbia Asthma & Allergy Clinic to use the phone number and/or email address provided to send me information regarding my appointments.

Patient name (printed) : ________________________________  DOB: _________

Patient signature: _____________________________________  Date: _________

Parent/guardian signature: ______________________________  Date: _________

Updated 11/2018
FINANCIAL POLICY

Method of Payment
We accept cash, check, Care Credit, and most major credit cards for your convenience. Returned NSF checks are subject to a $25 NSF fee and Company will no longer accept checks from patients who have written a returned NSF check. These patients will be asked to pay in an accepted alternative mean such as money order, credit card or cash for all future transactions.

New Patients and Referrals
Each patient’s primary care physician is responsible for coordinating his/her patients’ health care. If you are seen without a referral, depending on your plan type, you may be responsible for payment for all services rendered. We encourage patients to know the requirements of their specific health plan. For new patients without insurance, payment in full at the time of service is required. For all patients with insurance, we require copays to be paid at time of service. For insurance plans with high deductibles that have not yet been met, we require a deposit to be paid at time services are rendered and then billed for the difference. The deposit amount will vary dependent upon services being rendered at time of service and the amount of deductible needing to be met at time of service.

Usual & Customary Rate
Our clinic is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. You are responsible for paying any balance in full, regardless of your insurance company’s determination of usual and customary rates.

Billing for Insurance Accounts
Verification of benefits is not a guarantee of payment or eligibility. If your insurance company pays differently for any reason than estimated, you agree that you are responsible to pay any remaining balance within 30 days of notification by your insurance company. If after 60 days from filing your claim we have not received payment from your insurance carrier, we ask you to pay the remaining balance on your account.

Appointment Cancellations and Electronic Communication
We require a 24-hour notice of change of appointment or cancellation. Failure to comply may incur a $50.00 cancellation fee. We appreciate you as a patient, and cooperation in complying with this policy will assist us in providing the best care possible to all of our patients.

Billing Communication
There are occasions when one of our Billing Department staff members will need to verbally contact patients regarding their account. On the chance we are unable to reach you and get a voicemail, we ask that you check the appropriate box where you prefer to be contacted, including the number to call. This will allow us to leave more detailed information in our message to you. Please note this is only an authorization to specify what information we are allowed to leave on your voicemail if you do not answer when we call. (see next page)
I authorize the following and I understand I can opt out at any time by submitting a written request:

☐ CAAC Billing Department Representative is authorized to leave a detailed voice message on my home phone at: _________________________

☐ CAAC Billing Department Representative is authorized to leave a detailed voice message on my cell phone at: ___________________________

Patient Name (please print): ___________________________________ Date: _____________
Patient Signature: _____________________________________________________________
Guardian Signature: _________________________________________ Date: _____________

Our goal is helping you understand your coverage. Verification of benefits is not a guarantee of payment. Please be advised, you are ultimately responsible for payment. You are responsible to notify Columbia Asthma and Allergy of any changes to your insurance, address, or payment plan. Please do not hesitate to ask about any of our policies.