

Patient Name: _____

Date of Birth: ____/____/____

ASTHMA AND ALLERGY CLINIC, P.A.
GEETA KHARE, M.D.
2687 Jenks Ave.
Panama City, FL 32405

Patient Information:

Last Name: _____ First: _____ M.I. _____

Date of Birth: _____ Gender: Male Female

Race: White African American Asian American Indian Black Hispanic
 White Hispanic Native Hawaiian / Pacific Islander None / Refuse

Social Security Number: _____ Driver License # _____

Marital Status: Single Married Widow Divorced Separated

Street Address: _____

City: _____ State _____ Zip _____

Email address: _____@_____

Home Phone _____ Cell Phone: _____

Employer _____ Work Phone _____ Ext. _____

School _____

What is your preference for us to contact you? Home phone Cell Phone Email

Referring Physician: _____ Phone: _____

Pharmacy Preference: _____ **Address:** _____

Emergency Contact Information:

Name: _____ Phone: _____

Relationship to Patient: _____

If the patient is a minor child or under guardianship, then please fill out page 2. The signature below must match page 2 information and Driver's License.

I attest that the above information is correct and I have the legal authority to authorize medical treatment.

Patient Signature: _____ Date: _____

Patient Name: _____

Date of Birth: ___/___/___

Please fill out this form if you are the parent of a minor or legally responsible for the patient

(The person legally responsible for minor or under guardianship is to fill out top portion of form)

Name: _____ Phone: _____

Date of Birth: _____ Gender: Male Female

Social Security Number: _____ Driver License # _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email address: _____@_____

Home Phone _____ Cell Phone: _____

Relationship to patient: Parent Legal Guardian Other: _____

Does Patient Reside with: Mother Father Both Other: _____

Who has legal custody or guardianship of the patient? _____

Are there any custody issues or conflicts that we should be aware of? yes no

If yes, please explain (on back of the form):

The purpose of this section is to allow you the parent or legal guardian, the option of naming other adults to bring your child (or person under your guardianship) to the office of Geeta Khare M.D. for medical evaluation and treatment. You will be giving permission for these adults to discuss the decisions regarding the medical care of the patient.

If there are no adults listed, then patient will only be seen when brought by the Parent or Legal Guardian listed above.

Who is allowed to bring the patient in for office visits and treatment:

Date	Name of Adult	Relationship to Patient	Phone Number	Date Canceled

I attest that the above information is correct and I have the legal authority to authorize medical treatment.

Signature: _____ Date: _____

Patient Name: _____ Date: _____

Patient Name: _____

Date of Birth: ____/____/____

PAYMENT POLICIES

- **It is the policy of this office that the parent or legal guardian presenting the patient for treatment is responsible for payment of the patient portion of charges.**
- We make every effort to keep down the cost of your medical care. Our office fees are determined by the complexity of the procedure, the time involved, and the fee that is usual and customary for our area.
- Payment of the patient portion is expected at the time of service. We will send you a statement after we have received information from your insurance company and payment. The balance on your statement is due and payable in full when the statement is issued. If your account becomes past due by 60 days, and you have not made payment arrangements, your account will be turned over to a collection agency and you will be dismissed from the practice. You will be responsible for all collection expenses.
- We are aware that at times medical bills can be overwhelming. We make every effort to work with each patient on an individual basis to assist in making payment arrangements. It is your responsibility to call and set up a payment plan.
- If you have set up a payment plan, a payment will be required each/every month. Failure to adhere to the agreed payment plan will forfeit the payment arrangement and the account will be due in full. If you do not then pay your account in full or contact us with relevant information, your account will be turned over to a collection agency and you will be dismissed from the practice.
- Please note that due to legal requirements and contractual obligations, we must charge and collect for all co pays and deductibles.

NON-COVERED SERVICES

- Non Sufficient Funds returned checks will require complete payment in cash, credit card or money order for the amount of the check PLUS a \$25.00 fee. Those patients who have an Non Sufficient Funds returned check will be required to pay for all future services with cash, credit card or money order.
- Copies of your medical records will cost \$1.00 per page. This charge is the responsibility of the patient for copies sent to the patient or any third party. This charge MAY be waived under certain circumstances. This charge must be paid in full before copies will be made.
- If you require a Physician Statement, Special form, or Special Letter, this is NOT covered by your insurance. There is a separate fee for those services. These fees also must be paid in advance before the forms/letters will be filled out. Depending on the length and complexity of the form/letter you may be asked to make an additional appointment and it could take up to 30 days to be completed.

*****DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM! *****

I HAVE READ THE ABOVE FINANCIAL POLICIES AND AGREE TO COMPLY WITH THEM.

Signature: _____ Date: _____

Printed Name: _____

Patient Name: _____

Date of Birth: ____/____/____

OFFICE POLICY REGARDING INSURANCE

- At Asthma and Allergy Clinic, P.A., we are happy to file with your insurance company. However, please understand that your insurance coverage and benefit levels are an agreement between you and your insurance company. It is your responsibility to determine your benefits and you will be responsible for the charges incurred for evaluation and treatment. In order to file with your insurance company, we require that all information provided be accurate and complete. If the information you provide to us is not complete and accurate, we may not be able to file your insurance and you will be responsible for the entire bill.
- We charge what is usual and customary for our area. We are not responsible for any insurance company's arbitrary determination of payment schedules. You may incur charges for services not covered by your plan. You will be responsible for these charges regardless of your insurance coverage.
- If you have more than one insurance, you will need to accurately determine which is the primary insurance and which is the secondary insurance. Please note that errors in filing with the appropriate primary insurance first may result in a denial of payment by your insurance carrier.
- While we can file with your primary and secondary insurances, we cannot file with more than two insurances. If you have more than two insurance policies, we will be happy to provide you with a copy of your encounter form so that you can submit a claim for reimbursement directly to additional insurance company after the first two insurance policies have paid.
- We will collect your "estimated patient portion" at the time of your office visit. This includes any Co-pays, coinsurances and deductibles. You will be responsible for any balances left over after your insurance has paid
- Please notify us of any changes in your insurance status when you check in. Most insurance companies will not pay after 90 days. You – the patient, parent or guardian—receive the same Explanation of Benefits that we do. Please DO NOT ignore these EOB's. It is your responsibility to update your insurance. If you fail to update the insurance, you will be responsible for the entire balance that the insurance company denies.
- If your insurance plan will only allow you to see physicians that are members of their network, please verify that we do participate with your particular plan.
- It is the responsibility of the patient to review his/her insurance coverage and to know if a referral is necessary, if pre-certification is required and/or if a second opinion is necessary.

PRIMARY INSURANCE

Insurance Company _____

Policy Holder's Name: _____ Relation to Patient: _____

Birthdate _____ SS# _____

SECONDARY INSURANCE

Insurance Company _____

Policy Holder's Name: _____ Relation to Patient: _____

Birth date _____ SS# _____

Patient Name: _____

Date of Birth: ____/____/____

This section to be filled out if you have insurance.

OPTION 1

If you wish for us to file with your insurance, please initial each paragraph below and sign in the signature line.

- _____ (Initial) **Assignment of Benefits:** I request that payment of authorized benefits from my insurance carrier(s) be made on my behalf directly to Asthma and Allergy Clinic, P.A., for services furnished to me by Geeta Khare, M.D. A copy of my original signature on file will be considered a valid authorization and may be substituted for the original signature
- _____ (Initial) **Release of Information:** I further grant Asthma and Allergy Clinic, P.A. and Geeta Khare, M.D. permission to release the necessary medical information regarding my diagnosis and treatment to substantiate this or any related claim for benefits to my insurance carrier(s) or its intermediaries.
- _____ (Initial) **Lifetime Authorization:** I understand that this authorization to pay and release information will be considered a lifetime authorization by me unless I revoke it. I certify that the information given regarding benefits is valid and correct.
- _____ (Initial) **Financial Responsibility:** I understand that insurance coverage is an agreement between the carrier and me and is not a substitute for payment. I am personally responsible for deductibles, co-pays, and any unpaid balances. I will also be responsible for any collection expenses necessary to collect on my account.

Please sign that you have read and understand the policy regarding filing your insurance.

Signature: _____ **Date** _____

If you do not have insurance fill out this section.

OPTION 2

- _____ (Initial) Please do not file my insurance company. I will file my own claims and pay in full at the time of service for care rendered at Asthma and Allergy Clinic P.A
- _____ (Initial) I do not have insurance and I will pay in full the cost of services rendered here at Asthma and Allergy Clinic P.A

Please sign that you have read and understand the policy regarding filing your insurance.

Signature: _____ **Date** _____

Patient Name: _____

Date of Birth: ____/____/____

LEVEL AND COORDINATION OF CARE

- It is our policy to send a copy of progress notes to the referring physician. This is to facilitate your treatment and to avoid conflicting therapies.
- This is a specialty clinic. Please see your primary physician for all general medical problems as well as for routine illnesses such as colds and other general health problems.

APPOINTMENTS, CANCELLATIONS, NO-SHOWS

- In our efforts to provide the best possible care at the lowest possible cost and to allow for other patients in need of care to be accommodated, please call our office as soon as possible before your appointment if you need to change or cancel your appointment.
- Any patient who does not show up for a scheduled appointment and has not informed the office in advance will be considered a "NO SHOW."
- The practice reserves the right to discontinue the physician-patient relationship with any patient who is a NO SHOW . If the relationship is discontinued, the patient will receive written notification of that decision.
- Families will not be allowed to make appointments for any family member after a NO SHOW has occurred.

PRESCRIPTION REFILLS

- We will make every effort to write your prescriptions with sufficient refills to last until your next appointment. However, if your prescription refills run out prior to your follow up appointment, please call us or have your pharmacy contact us to authorize additional refills.
- **Note that prescription refill requests require two business days notice. For your safety, do not let yourself run out of medications before requesting refills.**
- Prescriptions will be provided only for current or **ongoing** medications.
- **New medications, narcotics and antibiotics will not be called in. These medications require an office visit.**

AFTER HOURS CARE

- The doctor is available for urgent medical matters when the office is closed. To contact her, you must call the regular office number: 850-747-3665 and leave a message on the recorder. The phone system will then page the doctor and she will retrieve the message.
- Please clearly state your name, the patient's name, a call back number, a detailed description of the urgent medical matter
- If the above information is not given, your call may not be returned.
- If you use "Anonymous Call Rejection", you must remove this service (by dialing *87) in order for your call to be returned
- Please understand that diagnosis and treatment over the phone is difficult and limited. **If your matter is complex or if you have not been seen recently, you may be asked to go to the Emergency Room.**

OTHER MATTERS

- For the safety of our patients with respiratory illnesses, we ask that you refrain from wearing perfume to the office. If you are coughing or have a fever, we ask that you wear a mask to protect other patients and staff.

I HAVE READ THE ABOVE OFFICE POLICIES AND AGREE TO COMPLY WITH THEM.

Signature: _____ Date: _____

Printed Name: _____

Patient Name: _____

Date of Birth: ____/____/____

Notice of Privacy Practices

Acknowledgement of Receipt

I, _____ acknowledge receipt of Asthma and Allergy Clinic, PA's Notice of Privacy which was effective April 7, 2003.

Patient Signature: _____

Patient Printed Name: _____

Date Signed: _____

For office use only:

We were unable to obtain a written Acknowledgement of Receipt for the following reason(s):

Printed Name: _____

Written Name: _____

Title: _____

Date: _____

MHS
6 years

Retain

**Asthma and Allergy Clinic, P.A.
Medical History**

Last Name: _____ **First Name:** _____ **M.I.** _____ **Date of Birth:** _____

Referring Physician: _____ **Date of visit:** _____

Past and Current Illnesses Circle if the patient currently has or has had in the past:

Hay fever	Adverse Drug Reaction	Arthritis	Stomach Problems
Asthma	Chronic Bronchitis	Diabetes	HIV/AIDS
Hives	Tuberculosis	Epilepsy	Glaucoma
Atopic Dermatitis	Anemia	Chronic Headache	Cataracts
Chronic Sinus Problems	Hypertension	Kidney Disease	Thyroid Disease
Nasal Polyps	Stroke	Liver Disease	Pneumonia
Insect Sting Allergy	Heart Disease	Cancer	Depression
Other:	Other:		

Hospital History:

Hospitalizations and Surgeries:	Reason?

Current Medications:

List all medications that you currently take (include over the counter preparations, vitamins and supplements):

MEDICATION NAME	Amount	Times Taken per Day	For what reason do you take it?

* additional medications that you currently take (include over the counter preparations, vitamins and supplements) write on back of this form or **attach a separate sheet of paper**

Reactions:

List all medications you do not tolerate:

MEDICATION	REACTION	DATE

List all foods you do not tolerate:

FOOD	REACTION	DATE

Name: _____

DOB: _____

Family Medical History: Check if there is any history in your family?

Family History Follow lines across the page. Mark appropriate box.	Alive & Well	Deceased	Age of Death	Cause of Death	Hayfever	Asthma	Nasal Polyps	COPD	Cystic Fibrosis	High Blood Pressure	Diabetes	Recurrent Infections	Cancer	Other	Other	Other
Mother																
Father																
Brother																
Sister																
Other:																

* Please use reverse side for additional information.

SOCIAL HISTORY

Relationship Status: Married Single Widowed Divorced Partnered Number of other people living in home: _____

Occupation: _____ Do the symptoms improve or worsen at work?

Explain: _____

List hobbies and recreational activities: _____

Smoking Status: Current every day smoker Current sometimes smoker Former smoker Never Smoke

Cigarettes Cigars e-cigarettes _____mg or vapors _____mg Pipe Smokeless tobacco Age started: _____
Amount used daily: _____
Quit Date: _____

On a Scale of 0 - 10, where 0 is definitely not important/ not ready to quit using tobacco and 10 is definitely important/ready to quit, what number best reflects how ready you are to quit. 0 1 2 3 4 5 6 7 8 9 10

Alcohol Yes No What type: _____ Amount per day _____ per week _____ per month _____

Recreational Drugs: Yes No What type: _____ Amount per day _____ per week _____ per month _____

Environmental Survey:

Any recent water damage in home? Yes No Problems with cockroaches mice other pest
Are there any smokers who live with this patient? Yes No Do they smoke in the home? Yes No
Are there any pets? Yes No How many pets _____ What type of pets: _____

Review of Systems: Circle any of the following that apply

CONSTITUTIONAL SYMPTOMS: fever weight loss extreme fatigue

EYES: sudden loss of vision pain redness excessive tearing double vision

EARS, NOSE, MOUTH AND THROAT: sore throat runny nose ear pain

RESPIRATORY: cough shortness of breath wheezing

CARDIOVASCULAR: murmurs chest pain palpitations

GASTROINTESTINAL: Trouble swallowing heartburn nausea/vomiting abdominal pain constipation diarrhea blood in stools

SKIN: rashes itching dryness changing mole

NEUROLOGICAL: headache persistent weakness or numbness on one side of the body falling

PSYCHIATRIC: depression anxiety suicidal thoughts

GENITOUTINARY: irregular menses vaginal bleeding after menopause frequent or painful urination bloody urine impotence

MUSCULOSKELETAL: join pain muscle weakness

Endocrine: excessive thirst cold or heat intolerance breast mass

Hematologic: unusual bruising or bleeding enlarged lymph nodes

Allergic: hay fever Asthma hives anaphylaxis

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.

Uses and Disclosures:

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as protected information (PHI), serves several purposes. At Asthma and Allergy Clinic, PA, these include:

Treatment:

- Basis for planning your care and treatment
- Communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means of documenting laboratory test results and radiological examinations
- A record of your medical history from which you can obtain a copy to transfer to another health professional

Payment:

- Means by which you or a third-party payer can verify that services billed were actually provided
- Business office can use your health information to bill you or your insurance company for services provided
- Business office can use your health information to verify you have insurance coverage and what your insurance will cover
- Third-party payers can use your health information to coordinate benefits so they pay correctly
- Business office can use your health information to appeal non-payment of your claim to a third-party payer
- Assignment of benefits will be to the health care provider, as appropriate
- A collections agency can use your health information in their efforts to obtain payment of unpaid medical bills from our office

Health Care Operations:

- Means to educate allied health professionals
- Data source for medical research
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- Business office can use your health information to audit the billing process to detect and prevent fraud and abuse

Uses and Disclosures Unique to Asthma and Allergy Clinic, PA:

- We may contact you to provide appointment reminders and/or test results.
- We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- If the practice is sold, all patient records will be transferred to the new owner(s).
- Product vendors may visit the facility for observation or educational purposes (for example, pharmaceutical representatives).
- We will infer that you agree to the release of your protected health information, as appropriate, to your spouse or a friend if either of them accompanies you to the office for your appointment.

Asthma and Allergy Clinic, PA, may also use and/or give out your health information for the following reasons:

As required by the United States Department of Health and Human Services. This could be as part of an investigation or to determine if we are obeying the law.

- Protected information may be disclosed in the course of certain judicial or administrative proceedings.

- Medical information may be disclosed for law enforcement purposes or other specialized governmental functions.
- Your protected information may be disclosed as authorized by laws relating to workers' compensation or similar programs.

Asthma and Allergy Clinic, PA, will not use or disclose your protected information for any other purpose without your written authorization. Once given, you may reverse your authorization in writing at any time.

Individual Rights

You have the following rights regarding your protected health information:

- You may request restrictions in writing on certain uses and disclosures of your protected information. Asthma and Allergy Clinic, PA, is required to honor your request for any services paid out of pocket. However, in the case of covered services, in certain instances, Asthma and Allergy Clinic, PA , is not required to agree to your request restrictions.
- You have the right to receive communications from Asthma and Allergy Clinic, PA, in a confidential manner.
- You have the right to inspect and copy your medical information. This right is subject to certain specific exceptions and you may be charged a reasonable fee for any copies, mailing, and/or summarizing of your records.
- You have the right to request an amendment of your medical information. The request must be in writing and must include a reason that the amendment be included. Asthma and Allergy Clinic, PA, may deny your request for certain specific reasons. If denied, the organization will provide you with a written explanation for the denial and information regarding further rights you would have at that point.
- You have the right to receive a record of the disclosures of your medical information made by Asthma and Allergy Clinic, PA, in the six years prior to your request, except for disclosures for treatment and/or payment, and for certain other specific disclosure types.
- You have the right to request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to be notified if we have a security breach and protected health information (PHI) is released in error.

Our Duties

Asthma and Allergy Clinic, PA, is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices regarding protected health information. Asthma and Allergy Clinic, PA, is required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice and any revision will apply to all the protected health information we maintain. If Asthma and Allergy Clinic, PA, revises the terms of this Notice, we will post a revised notice and will make paper copies of this Notice of Privacy Practices for Protected Health Information available upon request.

Complaints

If you believe your privacy rights have been violated, you have the right to complain to Asthma and Allergy Clinic, PA, and/or to the United States Department of Health and Human Services. To complain to Asthma and Allergy Clinic, PA, please contact the organization's Privacy Officer at 850 747-3665 or by writing to Asthma and Allergy Clinic, PA at 2687 Jenks Avenue, Panama City, FL, 32405. If you choose to file a complaint, you will not be retaliated against in any way.

Contact Information

If you would like further information regarding your rights or regarding the uses and disclosures of your protected health information, you may contact Asthma and Allergy Clinic, PA,'s Privacy Officer at 850 747-3665.

Effective Date

This Notice is effective as of April 7, 2003. This notice has been updated according to the HIPAA Ominbus Final Rule, effective March 2013, and required as of September 23, 2013.

Notice of Privacy Practices Acknowledgement of Receipt

I, _____, acknowledge receipt of Asthma and Allergy Clinic, PA,'s Notice of Privacy Practices which was effective April 7, 2003.

Patient Signature: _____

Patient Printed Name: _____

Date Signed: _____

For office use only:

We were unable to obtain a written Acknowledgement of Receipt for the following reason(s):

Printed Name: _____

Written Name: _____

Title: _____

Date: _____

