NORTHERN ARIZONA ALLERGY, ASTHMA, & IMMUNOLOGY

PATIENT DEMOGRAPHICS AND HIPAA FORM

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ DOB: _____

AGE: _____ PREFERED LANGUAGE: _____ ETHNICITY: _____ GENDER: M / F

MAILING ADDRESS: _____

CITY/ STATE/ ZIPCODE: _____

CELL PHONE NUMBER: _____ HOME PHONE NUMBER: _____

PREFFERED PHARMACY / PHONE NUMBER: _____ OCCUPATION: _____

IF PATIENT IS A MINOR, PLEASE PROVIDE PARENTS/ GUARDIAN NAME: _____

GUARANTOR INFORMATION/ RESPONSIBLE PARTY:

LAST NAME: _____ FIRST NAME: _____ DOB: _____

AGE: _____ SSN: _____ GENDER: M / F

MAILING ADDRESS: _____ CITY/ STATE/ ZIPCODE: _____

CELL PHONE NUMBER: _____ HOME PHONE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ POLICY NUMBER/ SUBSCRIBER I.D.: _____

GROUP NUMBER: _____ EFFECTIVE DATES: _____ POLICY HOLDER DOB: _____

ADDRESS: _____ CITY/ STATE/ ZIPCODE: _____

INSURANCE PHONE NUMBER: _____ PT RELATIONSHIP TO SUBSCRIBER: _____

SECONDARY INSURANCE: _____ POLICY NUMBER/ SUBSCRIBER I.D.: _____

GROUP NUMBER: _____ EFFECTIVE DATES: _____ POLICY HOLDER DOB: _____

ADDRESS: _____ CITY/ STATE/ ZIPCODE: _____

INSURANCE PHONE NUMBER: _____ PT RELATIONSHIP TO SUBSCRIBER: _____

CONTACT INFORMATION:

*** PLEASE PROVIDE A CONTACT NAME AND A DIRECT PHONE NUMBER OR A CONFIDENTIAL MESSAGE LINE IN ORDER FOR OUR OFFICE TO NOTIFY YOU / THE PATIENT OF ANY RESULTS, APPOINTMENTS, BILLING INFORMATION, ETC. BY PROVIDING THIS CONTACT INFORMATION, YOU ARE GIVING OUR OFFICE PERMISSION TO LEAVE MESSAGES REGARDING PRIVATE INFORMATION ABOUT YOU/ THE PATIENT.*

CONFIDENTIAL PHONE NUMBER: _____ ***MESSAGE LINE:*** _____

IN ORDER TO RELEASE YOUR MEDICAL RECORDS TO ANOTHER PARTY, PLEASE FILL OUT THE "PATIENT DISCLOSURE FORM".

OUR OFFICE WILL SUBMIT A CLAIM TO YOUR INSURANCE AS A COURTESY, HOWEVER, OFFICE VISITS, COPAYS, AND DEDUCTIBLES ARE PAYABLE ON THE DATE OF SERVICE. INSURED PARTY WILL BE RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.
I HAVE READ THE ABOVE INFORMATION AND PROVIDED ALL CURRENT AND HONEST INFORMATION. I FULLY UNDERSTAND THIS INFORMATION AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

PATIENT/ LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ D. O. B. _____

Patient Consent for the Use/ Disclosure of Protected Health Information

I understand my/ the patient's health information is private and confidential. I understand the Northern Arizona Allergy works hard to protect my / the patient's privacy and preserve the confidentiality of my/ the patient's health information.

I understand that Northern Arizona Allergy may use and disclose my/ the patient's health information to provide treatment to me/ the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosure of information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. (One example would be if you/ the patient threatened to hurt someone.)

Northern Arizona Allergy has a detailed document labelled the "Notice of Privacy Practices". It contains the detailed instructions and protocols regarding the use and disclosure of health information. I understand I have the legal right to read the "Notice of Privacy Practices" before I sign this consent.

Northern Arizona Allergy may update this form accordingly. If I ask, Northern Arizona Allergy will provide me with the most current "Notice of Privacy Practices" form.

Under the terms of this consent, I can ask Northern Arizona Allergy to restrict how my/ the patient's health information is used or disclosed. I understand that Northern Arizona Allergy does not have to agree to my/ the patient's request. If Northern Arizona Allergy does agree to my/ the patient's request, I understand that Northern Arizona Allergy will agree to follow these limits.

I may cancel this consent in writing at any time by doing the following:

1. You/ the patient must provide a letter that has been signed and dated appropriately to Northern Arizona Allergy. If I write a letter, it must say that "I want to revoke my/ the patient's consent to authorize the use and disclosure of my/ the patient's health information for treatment, payment, and healthcare operations."

If I revoke this consent, Northern Arizona Allergy does <u>not</u> have to provide any further healthcare services to me/ the patient.

My signature below indicates that I have read and have been given the chance to review a current copy of Northern Arizona Allergy's "Notice of Privacy Practices." My signature means that I agree to allow Northern Arizona Allergy to use and disclose my/ the patient's protected health information to carry out treatment, payment, and healthcare operations.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Patient name (please print) Relationship to patient

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