Patient Personal Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____ Gender: Male / Female

Mailing/Billing Address: _____ Apt #_____

City_____ State_____ Zip_____

Street Address: _____ Apt #_____

City_____ State_____ Zip_____

Home Ph # ( ) _____ Cell Ph # ( ) _____ Email: _____

Race/Ethnicity: □White/Caucasian □Black/African American □Asian/Pacific Islander □ Hispanic/Latino □Other □I decline to report

Employment

□Employed □Self-Employed □Unemployed □Child □Student □Retired □Disabled

Employer: _____ Work Ph # ( ) _____

Employer Address: _____

Responsible Party

Who is the Policy Holder on your insurance?

Name:_____ Date of Birth: _____ Relationship to you: _____

If Patient is a child who is financially responsible for payment?

Name:_____ Date of Birth: _____ Relationship to you: _____

Spouse or Parent Information

□ If Applicable: Marital Status: _____

Name: _____ Relationship to you: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____ Home Ph # ( ) _____

Employer: _____ Work Ph # ( ) _____

Name: _____ Relationship to you: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____ Home Ph # ( ) _____

Employer: _____ Work Ph # ( ) _____

Physician Information

Family Doctor (PCP): _____ Phone Number: ( ) _____

Referring Doctor: _____ Phone Number: ( ) _____

Emergency Contact – (Not Living With You)

Name: _____ Relationship to you: _____

Address: _____ Home Ph # ( ) _____

I authorize calls, voice/text messages, or letters to be sent to any numbers/addresses listed above. A photocopy of this authorization shall be considered valid as the original.

Patient / Guardian Signature: _____ **Date:** _____

Acknowledgements

Printed Name of Patient: _____ Date of Birth: _____

If the patient is a minor or legally unable sign please list the name of the person completing this form below.

Printed Name: _____ Relationship: _____

Notice of Privacy Practices

Your signature on this form acknowledges that you have received our Notice of Privacy Practices.

Date: _____ Signature: _____
(A photocopy of this authorization shall be considered valid as the original)

Consent to Access Patient's Online Consolidated Pharmacy Records

I authorize Allergy & Asthma Associates of the NRV to access my online consolidated pharmacy records in order to determine my medication history, and to reduce the possibility of prescription errors.

Date: _____ Signature: _____
(A photocopy of this authorization shall be considered valid as the original)

Consent to Treat – Assignment of Benefits – Financial Agreement

I give Allergy & Asthma Associates of the NRV permission to provide such medical care as may, in their opinion, be medically necessary. I have the right to discuss my care and treatment with my provider, and to refuse care or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of any procedure, treatment, or examination. I further give ongoing authorization for payment of insurance benefits to be made directly to this practice for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I am responsible to obtain any referrals required by my insurance. In the event of default, I agree to pay all collection fees, court costs and/or attorney fees incurred or imposed by Allergy & Asthma Associates of the NRV.

Date: _____ Signature: _____
(A photocopy of this authorization shall be considered valid as the original)

Notice of Deemed Consent

Virginia law 32.1-45.1 requires health care providers to notify you that the Hepatitis B and C and/or HIV (AIDS) Virus testing may be done on a sample of you blood if a health care worker is exposed to your blood or body fluids in a manner which might transmit these diseases. The following notice is to advise you that this policy is in effect at our clinic. Any testing will be performed at no cost to you.

If such an exposure occurs, you will be given information about the reason for your testing and will have the opportunity to ask questions about the process. If you blood test is positive for the disease(s) listed above, the attending physician will notify you and any person exposed, as well as the Virginia Department of Health.

Your signature below indicates that you have been informed of this law and that you authorize release of any information required to perform the testing outlined above.

Date: _____ Signature: _____
(A photocopy of this authorization shall be considered valid as the original)

Printed Name of Patient: _____ Date of Birth: _____

Test Results

I authorize Allergy & Asthma Associates of the NRV to leave test results on the answering machine / voicemail.

Date: _____ Signature: _____
(A photocopy of this authorization shall be considered valid as the original)

Designated Party – Permission to Share Limited Medical Information

Some patients wish to allow family members or others access to their medical information. This information might be communicated directly, by mail, or by answering machine messages.

Examples of this information would be:

- Appointment Dates and Times
- Your General Diagnosis and Treatment
- Your Allergy Injection Schedule/Information
- Picking Up Sample Medication or Prescriptions on your Behalf
- Test Results

I authorize the following individuals (friends and/or family members) to be allowed to access to certain limited medical information. This form MUST be completed even if you do not wish to list anyone.

For quick reference we do ask for parents to list themselves, although this may seem redundant/unnecessary it makes it easier for staff to quickly view authorized individuals.

1) Name: _____Date of Birth: _____

Telephone Number: ( ) _____ Relationship: _____

2) Name: _____Date of Birth: _____

Telephone Number: ( ) _____ Relationship: _____

3) ____ None

You may revoke anyone listed on this authorization at any time by writing the office or completing a new form. I understand I cannot revoke this authorization retroactively.

Date: _____ Signature: _____
(A photocopy of this authorization shall be considered valid as the original)

Proxy

Proxy forms will be required for:

- Any minors who will accompanied to follow up appointments or allergy shots with anyone other than a parent / legal guardian
- Any minors 16 or older who need permission to bring themselves to follow up appointments or allergy shots.

A parent/ legal guardian must be present for the Initial Appointment or Appointments with Testing unless prior arrangements have been made.

Printed Name of Patient: _____ Date of Birth: _____

Late Cancellation and No-Show Policy / Late Arrival Policy

There will be a **$20 charge** for a Late Cancellation OR No-Show Appointments.

This IS NOT billable to your insurance and is due PRIOR to scheduling another appointment.

Definitions:

Late Cancellation: Any scheduled appointment that is not canceled or rescheduled at least 24-hours in advance.

No-Show: Any scheduled appointment that is missed.

Established Patients who miss TWO scheduled appointments (within a year) without giving the office at least 24-hour notice may be dismissed from the practice.

New Patients who miss TWO consecutive initial office visits without giving at least 24-hour notice may not be permitted to schedule another appointment.

Late Arrival Policy:

If you are more than ten minutes late, you may be asked to reschedule your appointment. Every effort will be made to see the patient the same day but this is not always an option.

Date: _____ Signature: _____
(A photocopy of this authorization shall be considered valid as the original)

Allergy Screening Questionnaire

Printed Name of Patient: _____ **Date:** _____

Please complete this questionnaire to the best of your ability and bring the completed form to your visit

1) What is the **Primary Reason(s)** for your visit? _____

2) Please list all of your **Current Medications & Dose.**(Including Oxygen) ___ None Current Medications
If additional space is needed please attach a copy

Medication Name	Dose	Medication Name	Dose

3) Please list all of your **Medical Conditions / Problems**. ___ None

_____ _____

_____ _____

4) Please list any **Medication Allergies** and the **Reaction** it caused. ___ None

Medication Name	Dose	Medication Name	Dose

5) Please check or add any **Surgeries (Operations)** you have had. ____ None

☐ tonsils removed	☐ cataract extraction	☐ shoulder surgery	☐ mastectomy **If Yes: R / L**
☐ adenoids removed	☐ gallbladder removed	☐ neck surgery	☐ cardiac stents
☐ nasal surgery	☐ appendix removed	☐ hip replacement	☐ cardiac bypass
☐ turbinate reduction	☐ hernia repair	☐ knee replacement	☐ pacemaker
☐ sinus surgery	☐ hiatal hernia repair	☐ hysterectomy	☐ C-section
☐ palate trimmed	☐ back surgery	☐ other _____	

6) Please list **Specific Medications you have tried in the past** for this problem. ____ None
If additional space is needed please attach a copy. Please bring any creams if uncertain of strengths.

Singular: Yes / No Eye Drops: _____

Antihistamines/Decongestants: _____

Creams/Lotions: _____

Nasal Sprays: _____

Inhalers: _____

Printed Name of Patient: _____ **Date:** _____

7) Family History: ___ No family history of allergy conditions ___ Unknown family history

	Allergies/ Hay fever	Sinusitis	Asthma	Food Allergy	Bee Sting Allergy	Eczema	Hives	Angioedema	Recurrent Infections	Auto Immune
Mother										
Father										
Brother										
Sister										
Grandparent										

8) Home Characteristics:

- Who live in your household?
  ☐ spouse ☐ partner ☐ children ☐ alone ☐ roommate(s)
  ☐ mother ☐ father ☐ brother ☐ sister ☐ other_____
- Occupation: _____
  If None: ☐ unemployed at present ☐ retired ☐ disabled
- What type of home do you live in? ☐ house ☐ apartment ☐ townhouse ☐ mobile home ☐ other
- Location? ☐ town ☐ rural
- Basement? ☐ yes ☐ no **If Yes**: Is the Basement Damp? ☐ yes ☐ no
- Heat? ☐ electric ☐ oil ☐ gas ☐ inside woodstove ☐ outside woodstove ☐ heat pump
- Carpet? ☐ none ☐ minimal ☐ moderate ☐ throughout home
- Air Conditioning? ☐ yes ☐ no

9) Pets / Animal Exposure: ____ None
Do you have pets? Indoor pets: ☐ cat ☐ dog ☐ other_____
Outdoor pets: ☐ cat ☐ dog ☐ other_____

10) Smoking History:

- Are you or have you ever been a **smoker**? ☐ yes ☐ no
  - How many **packs daily** did you or do you smoke? _____
  - How many **years** have you or did you smoke? _____
  - What year did you **stop** smoking? _____
- Do you vape? ☐ yes ☐ no **If Yes:** ☐ daily ☐ other: _____
- Does anyone else smoke/ vape in your home? ☐ yes ☐ no **If Yes**: ☐ spouse/partner ☐ parent ☐sibling

11) Please list the name of one local pharmacy you prefer to use.

_____ _____
Name **Location**

If you use a **mail-in pharmacy**, list it here: _____

Check who you have **prescription insurance** coverage with (this is different from your healthcare insurance)

☐ Aetna Rx ☐ CVS Caremark ☐ Cigna Rx ☐ Envision Rx
☐ Express Scripts/Medco ☐ Optum Rx ☐ Humana Mail Order ☐ Silverscript
☐ Tricare ☐ ChampVA ☐ Walgreens Mail Service ☐ Other _____

Allergy & Asthma Associates of the NRV
Kristina L. Kwak, M.D.
Diplomate: Allergy & Immunology

Main Office
2955 Market Street, Suite B-1
Christiansburg, VA 24073

Main Office
Telephone: (540) 381-7686
Fax: (540) 779-0003

Satellite Office
590 W. Ridge Road, Suite F
Wytheville, VA 24382
Telephone (276) 228-3126

NOTICE OF PATIENT PRIVACY RIGHTS

Allergy & Asthma Associates of the NRV
Effective Date: July 1, 2018

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During the course of your relationship with Allergy & Asthma Associates of the NRV, we will create and obtain information about your health care. This information will be kept in your chart (your medical record), and will include office visit notes, results of lab tests and x-rays, records obtained from other health care providers, and insurance payment information, as well as other documents. Your medical record is the physical property of Allergy & Asthma Associates of the NRV, but the information contained in it belongs to you. This information is confidential, and we will protect it from inappropriate use or disclosure.

1. **Our practice is allowed by law to use and disclose your protected health information without your written authorization for the purpose of treatment, payment, and health care operations.** We will give you a Consent Form to sign which documents that you understand that your health information may be used and disclosed without your written authorization under the following circumstances:
    - ***For your treatment.*** For example: Information about you may be released to your family doctor in order to coordinate your care. A diagnosis of your medical condition may be disclosed to a home health provider on an order for equipment. Or a symptom you are experiencing may be released to a hospital radiology department in order to document your need for an x-ray.
    - ***For payment.*** For example: Your diagnosis and treatment information may be submitted on a claim to your insurance carrier in order to obtain payment for your office visit. Or a copy of your office notes may be sent to your insurance carrier in order to document medical necessity.
    - ***For health care operations*.** For example: Your insurance carrier may review information from your record in order to perform quality assessment of our services.
2. **We may share some limited information with persons involved in your care, such as family members or other persons as designated by you.**

    - Examples of this shared information are: appointment dates and times, the date of your next scheduled injection, and allowing a family member or friend to pick up samples of medications for you.
    - We may leave limited information on your home answering machine or with an individual who answers your home phone if you are not at home when we call.
    - If you wish to approve a friend to receive the limited information described above, or if you do not wish us to share limited information as described above with a family member, please notify the receptionist.
3. **Your health information may also be used or disclosed without your written consent or authorization under other circumstances, providing certain conditions are met.** Some examples are as follows:
    - In response to the reasonable belief that an individual may be a victim of abuse, neglect, or domestic violence (such as to a social services agency or a protective services agency)
    - In response to judicial and administrative proceedings (such as in response to a valid subpoena)
    - For law enforcement purposes (such as providing limited information to identify and locate a fugitive or material witness)

- For public health activities (such as to an authority collecting information to control disease)
- For health oversight activities (such as in audits, or in civil or criminal investigations)
- About decedents (such as to a coroner or funeral director)
- For research purposes (no information will be linked to your personal identity)
- To avert a serious threat to health or safety (such as to law enforcement officials to identify or apprehend an individual)
- For specialized government functions (such as to federal officials for the conduct of lawful intelligence or to a correctional institution about an inmate)
- For workers' compensation

4. **<u>Uses and disclosures other than those listed above in Sections 1 and 2 require your written authorization</u>. Your authorization is a detailed document which gives us permission to:**
    - Use your health information for a purpose you have specified (which is other than treatment, payment, or health care operations), or to
    - Disclose your information to a third party specified by you.
    - You may revoke your authorization; you must request this in writing
5. **Your authorization is required for** sale of your information, or for use or disclosure of your information for marketing purposes.
6. **Your authorization is required for** use or disclosure of any of your psychotherapy notes.
7. **Our practice may contact you to:**
    - Remind you of appointments (sometimes in the form of a postcard reminder for allergy shots),
    - Give you information about treatment alternatives which may be of interest to you, or
    - Offer you the opportunity to be considered for participation in a clinical research study.
8. **You have the right to:**
    - Restrict disclosures to your health plan for the purpose of payment or health care operations when the information pertains solely to an item or service for which you have paid us in full. Please notify us of your wishes by completing a Restriction Form before you leave your visit.
    - Request restrictions on certain other uses and disclosures.
    - Receive confidential communications of your health information (please specify method in writing)
    - Inspect and copy your health information, including an electronic copy if requested
    - Amend your health information (A practice has the right to deny the amendment under certain circumstances)
    - Receive an accounting of our disclosures of your information
    - Receive a paper copy of this Notice
9. **Our practice has the following responsibilities:**
    - We will maintain the privacy of your protected health information, and will provide you with notice of our legal duties and privacy practices with regard to your health information
    - We will abide by the terms of the notice currently in effect at the time of disclosure
    - If we change our privacy practices as described in our Notice, we will provide you with a revised Notice.
10. **If you feel your privacy rights have been violated,** you may complain to our Privacy Officer, Ashley Puckett at (540) 381-7686, or write to her care of:

    Allergy & Asthma Associates of the NRV
    2955 Market Street, Suite B-1
    Christiansburg, VA 24073

    - You may also file a complaint with the Secretary of Health and Human Services
    - There will be no retaliation against you if you file a complaint.
11. **You may obtain a summary copy of the privacy regulation** from our office on request; or from the Department of Health and Human Services.
12. **Allergy & Asthma Associates of the NRV reserves the right to change the terms of our Notice** and to make the new notice provisions effective for all protected health information we maintain. If we change our privacy practices, we will provide you with a copy of our revised Notice at the time of your next office visit.
13. **If you have questions or would like further information,** you may speak to our Privacy Officer, Ashley Puckett at (540) 381-7686.