Allergy, Asthma, Immunology & Rheumatology Institute

Kristin L. Bussey-Smith, MD

Patient Information

Patient's Full Name_____
First Middle Last

Mailing Address_____
Street Number/Street (Apt) City State Zip

Email_____

Home Phone _____Cell Phone _____Work Phone _____

Employer_____ Occupation_____

Date of Birth_____ Male____ Female____ SSN_____

Race: □ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or Other Pacific Islander
□ White

Ethnicity: □ Hispanic/Latino
□ Non-Hispanic

Preferred Language _____

Referring Doctor_____ Preferred Pharmacy_____
Name and Address and/or phone number

Responsible Party Information (If different than patient)

Guarantor's Full Name_____ Relationship to Patient_____

Mailing Address_____

Home Phone _____ Cell Phone _____Work Phone _____

Employer_____Occupation_____

Date of Birth _____SSN_____

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Spouse Information

Spouse's Name _____

Date of Birth _____ SSN _____ Cell Phone _____

Employer _____ Occupation _____ Work Phone_____

Primary Insurance Information

Name _____

Address_____
Street City State Zip

Phone_____Policy#_____Group#_____

Policyholder's Full Name _____ SSN_____

Secondary Insurance Information

Name_____

Address_____
Street City State Zip

Phone _____Policy #_____Group #_____

Policyholder's Full Name _____ SSN_____

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Emergency Contact Information

Name_____
First Last

Phone_____
Home Cell Other

Relationship to patient_____

Address_____
Street Number/Street (Apt) City State Zip

_____
Name of Patient Signature of Patient or Patient's Parent/Guardian Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to request and receive a copy of this document.

_____
Name of Patient

_____
Signature of Patient or Patient's Parent/Guardian

_____
Date

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Authorization to Disclose Health Information

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____(optional)

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address:_____

This information may be disclosed TO and used by the following individual or organization:

_____ Address:_____

For the purpose of:_____

Please release the following: {Note: list not required by HIPAA}

___Entire Record

or:
- ___Problem List
- ___Progress Notes
- ___History/Physical Exam
- ___Medication List
- ___Immunization Record
- ___List of Allergies
- ___Other (Specify)_____
- ___X-Ray/Imaging Reports-from (date)_____ to (date)_____
- ___X-Ray Films
- ___Laboratory Results-from (date)_____to (date)_____
- ___EKG Reports
- ___Genetic Testing Information
- ___Other Diagnostic Reports (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___Yes, I consent to the release of this information. ___ No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the clinic's privacy officer.

_____ _____

Signature of Patient or Legal Representative — Date

_____ _____

Relationship to Patient (If Legal Representative) — Witness

IF RELEASING RECORDS TO PATIENT, COMPLETE THE FOLLOWING:

I understand that my medical record may contain reports, test results, and notes that only my physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Dr. Kristin Bussey-Smith, or AAIR responsible/liable for any misinterpretation of the information contained in these entries.

_____ _____

Signature of Patient or Legal Representative — Date

Relationship to Patient: _____ Witness:_____

Allergy, Asthma, Immunology & Rheumatology Institute
Kristin L. Bussey-Smith, MD

Authorization for Release of Diagnostic Reports and Electronic Information

I authorize Dr. Kristin Bussey-Smith and the staff of the Allergy, Asthma, Immunology & Rheumatology Institute to leave diagnostic test results pertaining to my medical care (or if patient is a minor, for my dependent/child's medical care) on my answering machine and/or voicemail. (Please choose one option below and sign next to the option you choose.)

_____ YES Signature:_____Date:_____

_____ NO Signature:_____Date:_____

I authorize Dr. Kristin Bussey-Smith and the staff of the Allergy, Asthma, Immunology & Rheumatology Institute to provide me non-urgent information for myself (or if patient is a minor, for my dependent/child) by electronic mail or messaging system.

Example of an email notification for diagnostic test results:

> *Dear Mrs. Jones,*
> *Your test results are now available. Please contact our office to make an appointment to review the results.*
> *Sincerely,*
> *Dr. Bussey-Smith, and the AAIR staff*

(Please choose one option below and sign next to the option you choose.)

_____ YES Email Address: _____

Signature:_____Date:_____

_____ NO Signature:_____Date:_____

Allergy, Asthma, Immunology & Rheumatology Institute
Kristin L. Bussey-Smith, MD

Patient Financial Policy

1. It is my responsibility to be aware of the details of my health care coverage as provided by my medical insurance plan. I will come prepared to pay my copay, coinsurance and/or deductible at the time services are rendered. I understand that if I fail to pay my copay, coinsurance, and/or deductible at the time of services, I may be subject to a $10 late fee. If my account becomes delinquent, I acknowledge that my account may be sent to a collection agency, and that I will be responsible for the collection fee, in addition to my account balance.

2. I understand that the office of Dr. Kristin Bussey-Smith, MD, PA will submit claims to my insurance company for medically covered services. I will pay for all services not covered by my insurance company.

3. I acknowledge that the office of Dr. Kristin Bussey-Smith, MD, PA will make a good faith effort to verify eligibility and benefits for my insurance. This is an estimate of the benefits provided, and not a guarantee of coverage or payment by my insurance carrier. I acknowledge that any payment from my insurance carrier is subject to coordination of benefits, policy provisions and exclusions, and coverage on the date that services are rendered.

4. If my insurance is an out of network carrier, I will pay my bill in full at the time services are rendered. If I cannot pay my bill in full, I understand a payment plan must be arranged with the front office/billing staff.

5. I understand that the office of Dr. Kristin Bussey-Smith accepts cash, personal checks, and credit cards (Visa and MasterCard). I understand there is a $35 fee on all returned checks, and that if I have a returned check, I may be required to pay in cash for all future payments.

6. I understand that all services provided in the hospital will be billed to my health insurance carrier. I will pay for the balance due and for any services not covered by my insurance plan.

7. I understand it is my responsibility to remember my scheduled appointment. The office of Dr. Kristin Bussey-Smith, MD, PA does not guarantee a "courtesy call" appointment reminder. I understand that I may be subject to a $35 cancellation fee if I cancel or do not keep my appointment without providing the office a 24 hour notice.

8. I understand that if I am more than 15 minutes late to my appointment, it will be determined that I did not keep my appointment, and the $35 cancellation fee may apply. Additionally, I may be asked to reschedule my appointment if I arrive more than 15 minutes late.

9. I understand that I will be financially responsible for services rendered for my child/minor.

_____
Patient Name

_____ _____
Patient Signature or Responsible Party Signature Date

Allergy, Asthma, Immunology & Rheumatology Institute
Kristin L. Bussey-Smith, MD

Assignment of Benefits Form

Financial Responsibility

I have read, understand, and agree to the Allergy, Asthma, Immunology & Rheumatology's (AAIR) Financial Policy. I understand that charges not covered by my insurance company, as well as my applicable co-payments, co-insurance, and deductibles are my responsibilities. All professional services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments if arrangements have been made in advance between AAIR and your insurance carrier(s).

I have requested medical services from AAIR on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary for AAIR to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and I agree to pay all such charges incurred in full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to AAIR for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize AAIR to: 1) Release any information necessary to insurance carriers, Medicare, or other third party payers, regarding my illness, treatments, and financial information as it pertains to my health care; 2) To process insurance claims generated in the course of examination or treatment; and 3) To allow photocopy of my signature to be used to process insurance claims.

I authorize AAIR to contact my insurance company and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to AAIR (Kristin Bussey-Smith, MD). This order will remain in effect until revoked by me in writing.

_____ _____

Patient Name | Responsible Party (Parent/Guardian)

_____ _____

Signature of Patient or Responsible Party | Date

Witness:_____

Allergy, Asthma, Immunology & Rheumatology Institute
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General Consent for Evaluation and Treatment

I,_____, have requested to be evaluated and treated by the Allergy, Asthma, Immunology & Rheumatology Institute (AAIR). I understand that certain office procedures may be appropriate for my medical evaluation and treatment. These procedures may include, but are not limited to, the following:

1. Allergy skin testing.
2. Joint fluid aspiration and/or injection(s).
3. Therapeutic medication injection(s).
4. Intra-dermal skin testing.
5. Drug or Food Allergy Testing and/or Incremental Challenge Testing.

The general risks of the above stated procedures include: pain, damage to skin or adjacent tissues at the injection and/or skin testing site, allergic reaction, infection, localized swelling, redness, and itching, as well as the need for further medical treatment, and potential death in extreme circumstances.

Before any of these procedures are performed (if they are deemed appropriate for my care), the risks and benefits will again be reviewed with me verbally, and I will be given time to have all of my questions and/or concerns addressed regarding the specific procedure(s).

I can withdrawal my consent for any diagnostic or treatment procedure at any time, verbally or in writing.

_____
Patient's Name

_____
Patient's or Patient's Parent/Guardian's Signature

_____
Date

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