



**GARRICK P. HUBBARD, M.D.   JENNY V. CASBURN, FNP-C   SAMANTHA PLITT, PA-C**

Dear New Patient:

We would like to welcome you to Allergy & Asthma Care of Indiana and look forward to caring for your allergy needs. We have three office locations; please be certain of the correct location for your appointment.

- ❖ 11590 North Meridian Street, Suite 400, Carmel, Indiana 46032
- ❖ 227 S Delaware St, Indianapolis, IN 46204
- ❖ HRH Professional Building, 1 Memorial Square, Suite 330, Greenfield, Indiana 46140

A parent or legal guardian must accompany all minors under 18 years of age. The initial visit to our office will often take 2 hours or more, and any necessary skin testing will most likely be completed during that time. Because we have set aside a significant amount of time for your appointment, if you need to cancel, please do so at least 24 hours in advance.

***It is extremely important that you read the “MEDICATIONS TO HOLD” information at least 10 days prior to your scheduled visit. If you feel you cannot do without your medication(s), please contact our office and discuss this with us.***

If you are currently taking any medications, please bring these with you. Otherwise, contact your doctor or pharmacist for a complete list of your medications. Please bring pertinent records, labs, and written reports of any imaging studies (x-rays, CT scans) with you.

It is helpful if you wear short sleeves to the appointment. All persons attending the appointment **MUST** refrain from using perfume and/or cologne on the day of your appointment with us. Also, please do not smoke and try to avoid being around smoke prior to coming into the office, as both of these irritants pose a significant health hazard to many of our patients.

Upon arrival, our receptionist will copy your picture ID and insurance card. We will also file an insurance claim for you. Per our Patient Financial Policy and contractual agreements with your health plan, **you will be required to pay your office visit co-pay at the time of your visit.** To assist you in making this payment, all of our offices accept MasterCard, Visa, American Express, and Discover. Our practice participates in the Medicare Program and with most commercial health insurance plans. However, it is your responsibility to verify with your health plan that the doctor you will be seeing is an enrolled provider, as health plan networks change frequently. If you have any questions about our participation in your plan(s), please contact our office. If your insurance requires a written authorization to see a specialist, please contact your primary care physician to obtain the referral PRIOR to your visit. Remember, your insurance agreement is between you and your insurance company. Any unpaid balance will be your responsibility.

Attached below, you will find several forms that we ask that you print and complete. Please bring the completed forms with you, as this will help to speed up your check-in. Please arrive 10-15 minutes prior to your scheduled appointment to allow time for us to process the information for your file. We appreciate your interest in our practice and look forward to helping you with any allergy and/or asthma treatment.

**MEDICATIONS TO HOLD FOR SKIN TESTS AND ORAL CHALLENGES**

Allergy & Asthma Care of Indiana

<b>STOP 7 or 10 DAYS BEFORE APPT.</b>	<b>STOP 3 DAYS BEFORE APPT.</b>	<b>DO NOT TAKE MORNING OF APPT.</b>	<b>LAST DOSE NIGHT BEFORE APPT.</b>
<p><b><u>*Antihistamines/ Cold Meds (7 days):</u></b>                      Allegra (fexofenadine), Alavert, Clarinex (desloratadine), Claritin (loratadine), Xyzal (levocetirizine), Zyrtec (cetirizine), Actifed, AlleRX, Bromfed (brompheniramine), Chlortrimeton, Codimal, Dimetapp, Duratuss, DuraVent, Rynatan, Rynatuss, Semprex-D, StaHist, Tavist (clemastine), Trinalin, Tussicaps, Tussi-12D, Tussionex, Allergy/Sinus meds, Dicel, Palgic, Atarax (hydroxyzine), Phenergan (promethazine)</p> <p><b><u>Eye Drops(7days):</u></b>                      Optivar, Zaditor, Alaway (ketotifen)</p> <p><b><u>Nasal Sprays (10 days):</u></b>                      Astelin, Astepro, Patanase, Dymista</p>	<p><b><u>*Antihistamines</u></b>                      Benadryl</p> <p><b><u>Heartburn meds:</u></b>                      Pepcid, Tagamet, Zantac, Axid,</p> <p><b><u>Vertigo/Dizziness Meds:</u></b>                      Antivert (meclizine)</p> <p><b><u>Eye Drops:</u></b>                      Elestat, Pataday, Patanol, Lastacaft.</p> <p><b><u>Over-the-counter pain/sleeping aids with "PM"</u></b>                      ex: Tylenol PM</p> <p><b><u>STOP 7 Days Prior:</u></b>  <b>**Irritable Bowel Meds (7days)</b>  <b>Hysoscyamine (Levsin, Levbid, Anaspaz, etc.)</b>  <b>Librax</b>  <b>Donnatel</b>  <b>Bentyl</b></p>	<p><b><u>• Inhalers:</u></b> Albuterol, Combivent, Maxair, Proventil, Terbutaline, Ventolin, Xopenex, ProAir, Atrovent</p> <p><b><u>• ONLY hold above inhalers IF symptoms allow</u></b></p> <p><b><u>If you have an afternoon appt, refrain from using inhalers after 8:00 am.</u></b></p>	<p>Advair, Foradil, Spiriva, Serevent, Symbicort, Dulera, Breo, Incruse, Anoro, Stiolto.</p> <hr/> <p align="center"><b><u>NO RESTRICTIONS:</u></b></p> <p><b><u>Inhalers:</u></b> Alvesco, Asmanex, Flovent, Intal, Pulmicort, QVAR, Arnuity.</p> <p><b><u>Nasal Sprays:</u></b>                      Flonase (fluticasone), Nasacort (triamcinolone), Nasonex, Omnaris, Veramyst, Zetonna, Fluosinolide, QNasl, Rhinocort</p> <p><b><u>Other:</u></b> Accolate, Singulair, Theophylline, Zyflo, topical steroid creams such as hydrocortisone cream</p>

**\*If evaluation is for hives, it is OK to continue antihistamines.**

**\*\*MUST** obtain permission from PCP BEFORE discontinuing the following medications; these medications need to be held 7 days OR LONGER.

**\*\*Antidepressants, sleeping aids:** doxepin, Elavil (amitriptyline), Norpramin (desipramine), Pamelor (nortriptyline), Surmontil (trimipramine), Vivactil (protriptyline)

If you have any questions, or you feel you cannot go without a medication, please contact us at 317-708-2839.

## ENVIRONMENTAL AND SOCIAL HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

What is the main concern(s) that brought you here today? \_\_\_\_\_

### HOME:

Do you live in a ...  City  Town  Rural Area

Do you live in a ...  House  Apartment  Other \_\_\_\_\_

How long have you lived in your current place of residence? \_\_\_\_\_ years \_\_\_\_\_ months. Age of home? \_\_\_\_\_

Basement?  Yes  No If yes, is your bedroom in the basement?  Yes  No  N/A

Are any areas of your home...  Damp  Musty  Seepage  Flooding

Do you have Dust Mite/Allergy Covers on the mattress  Yes  No On Pillows?  Yes  No

PETS: If applicable, please list number of pets and circle where they reside.  No Pets

Dog(s) \_\_\_\_\_ indoor/outdoor  Cat(s) \_\_\_\_\_ indoor/outdoor  Bird \_\_\_\_\_  Horse \_\_\_\_\_  Other \_\_\_\_\_

Do your pets go in the bedroom?  Yes  No  N/A

If minor, and split household: please list number of pets and circle where they reside in the 2<sup>nd</sup> household.  No Pets

Dog(s) \_\_\_\_\_ indoor/outdoor  Cat(s) \_\_\_\_\_ indoor/outdoor  Other \_\_\_\_\_  N/A

Do pets go in the bedroom at 2<sup>nd</sup> household?  Yes  No  N/A

SOCIAL HISTORY:  Smoker  Life-long Nonsmoker Exposed to 2<sup>nd</sup> Hand Smoke?  Yes  No

If Current/Previous Tobacco Use... How long? \_\_\_\_\_ How much? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Occupation \_\_\_\_\_ If pertinent, please list any occupational exposures: \_\_\_\_\_

### PAST MEDICAL HISTORY:

Medical problems/diagnoses: \_\_\_\_\_

Surgical procedures/year: \_\_\_\_\_

Hospitalizations/reason/year: \_\_\_\_\_

If patient is a child: Born full term?  Yes  No \_\_\_\_\_ (# weeks) Any complications?  No  Yes, list: \_\_\_\_\_

Normal growth?  Yes  No Normal development?  Yes  No Up to date on vaccines?  Yes  No

Is he/she in daycare or preschool?  No  Yes, number of days/week: \_\_\_\_\_

PREVIOUS MEDICATIONS: Please list any allergy/asthma/reflux medications you have tried in the past, for how long, and response

How many courses of antibiotics have you had in the past year? \_\_\_\_\_

Have you ever taken prednisone?  Yes  No If yes, how many times in the past year? \_\_\_\_\_ in your life? \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**REVIEW OF SYSTEMS** (Please check all that apply, or mark "NI" for normal if there are no problems)

General	<input type="checkbox"/> NI	<input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever or chills <input type="checkbox"/> Trouble sleeping
Skin	<input type="checkbox"/> NI	<input type="checkbox"/> Rashes <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Dry <input type="checkbox"/> Sensitive skin <input type="checkbox"/> Hair and nail changes
Head	<input type="checkbox"/> NI	<input type="checkbox"/> Headaches <input type="checkbox"/> Head injury <input type="checkbox"/> Neck Pain <input type="checkbox"/> Migraines <input type="checkbox"/> Wake up with headache
Ears	<input type="checkbox"/> NI	<input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Earache <input type="checkbox"/> Itching <input type="checkbox"/> Infections
Eyes	<input type="checkbox"/> NI	<input type="checkbox"/> Itching <input type="checkbox"/> Redness <input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Pain <input type="checkbox"/> Vision Loss/Changes <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma Last eye exam _____
Nose	<input type="checkbox"/> NI	<input type="checkbox"/> "Stuffy" <input type="checkbox"/> "Runny" <input type="checkbox"/> Itching <input type="checkbox"/> Sneezing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus pain <input type="checkbox"/> Sinus infections <input type="checkbox"/> Nasal Polyps
Throat/Voice	<input type="checkbox"/> NI	<input type="checkbox"/> Itching <input type="checkbox"/> Dentures <input type="checkbox"/> Dry mouth <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Thrush <input type="checkbox"/> Clearing throat frequently <input type="checkbox"/> Post nasal drainage
Lungs	<input type="checkbox"/> NI	<input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest tightness <input type="checkbox"/> Asthma <input type="checkbox"/> History of Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> COPD <input type="checkbox"/> Cough during/after exercise
Heart	<input type="checkbox"/> NI	<input type="checkbox"/> Chest pain <input type="checkbox"/> Heart disease <input type="checkbox"/> Palpitations or skipped beats <input type="checkbox"/> Swelling of feet/ankles <input type="checkbox"/> Shortness of breath with activity <input type="checkbox"/> Waking up from sleep gasping <input type="checkbox"/> High cholesterol
Stomach	<input type="checkbox"/> NI	<input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Heartburn <input type="checkbox"/> Change in appetite <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Nausea <input type="checkbox"/> Ulcers <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea
Urinary	<input type="checkbox"/> NI	<input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Burning or pain <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence
Joints/Muscles	<input type="checkbox"/> NI	<input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Back/neck pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Muscle weakness
Neurologic	<input type="checkbox"/> NI	<input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tremor
Hematologic	<input type="checkbox"/> NI	<input type="checkbox"/> Ease of bruising <input type="checkbox"/> Ease of bleeding <input type="checkbox"/> Blood Disorder
Endocrine	<input type="checkbox"/> NI	<input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Sweating <input type="checkbox"/> Frequent urination <input type="checkbox"/> Thirst <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disorder
Psychiatric	<input type="checkbox"/> NI	<input type="checkbox"/> Nervousness <input type="checkbox"/> Stress <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
Allergies to...	<input type="checkbox"/> None Known <input type="checkbox"/> Insect stings <input type="checkbox"/> Latex <input type="checkbox"/> Food <input type="checkbox"/> Medication Please list _____ _____ _____ _____	

**FAMILY HISTORY:** Does anyone in your family have nasal allergies or hay fever?  
 No  Parents  Siblings  Children  Other \_\_\_\_\_

Does anyone in your family have food allergies?  
 No  Parents  Siblings  Children  Other \_\_\_\_\_

Does anyone in your family have eczema?  
 No  Parents  Siblings  Children  Other \_\_\_\_\_

Does anyone in your family have cystic fibrosis?  
 No  Parents  Siblings  Children  Other \_\_\_\_\_

Does anyone in your family have COPD (Chronic Obstructive Pulmonary Disease)? If so, at what age were they diagnosed?  
 No  Parents  Siblings  Children  Other \_\_\_\_\_

**FAMILY MEMBERS:** Are any of your family members seen by our practice? Name(s)/Relationship \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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Treating patients of all ages

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Date \_\_\_\_\_

Name \_\_\_\_\_ Male/Female  
Last First Middle Nickname Single/Married

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone # ( ) \_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_ Preference : Home/Cell

Social Security# \_\_\_\_\_ DOB \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_

If patient is a minor, provide Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

**PRIMARY INSURED PARTY INFORMATION**

Name \_\_\_\_\_ Male Female DOB \_\_\_\_\_  
Last First Middle

SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Home Phone# ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_

**SECONDARY INSURED PARTY INFORMATION**

Name \_\_\_\_\_ Male Female DOB \_\_\_\_\_  
Last First Middle

SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Home Phone# ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ Cell# \_\_\_\_\_

**PRIMARY CARE PHYSICIAN- If none, mark  . Otherwise, please provide the following:**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

**REFERRED BY**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

**GARRICK P. HUBBARD, M.D. JENNY V. CASBURN, FNP-C SAMANTHA PLITT, PA-C**

**Limited Patient Authorization for Disclosure of Protected Health Information**

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: \_\_\_\_\_

SSN (last four digits): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Entity Requested to Release Information: Allergy & Asthma Care of IN

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity who is to receive your PHI):

Individual/Entity Name: \_\_\_\_\_ Individual/Entity Name: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record; **or**, check **only** those items of the record to be disclosed:

- |  |  |
|--|--|
| <input type="checkbox"/> office notes records                              | <input type="checkbox"/> nursing home, home health, hospice, and other physician records |
| <input type="checkbox"/> lab results, pathology reports                    | <input type="checkbox"/> record of HIV and communicable disease testing                  |
| <input type="checkbox"/> x-rays  | <input type="checkbox"/> record of mental health or substance abuse treatment            |
| <input type="checkbox"/> financial history report (previous 3 years only). | <input type="checkbox"/> Only send the following: _____                                  |

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

Patient Request       Other (please specify): \_\_\_\_\_

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: \_\_\_\_\_
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

\_\_\_\_\_  
patient or authorized representative signature

\_\_\_\_\_  
date

You have the right to receive a copy of signed authorizations upon request.

## PATIENT FINANCIAL POLICY

Thank you for choosing us as your specialty health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. Our staff is trained to inform you of the financial policies of this practice. This document must be read and signed by each patient and will remain in effect for all services rendered during your time as a patient in our practice.

**INFORMATION:** A current registration will be on file in the patient chart during the time that the patient is considered active. Patient registration will be updated yearly and will include numbers for the patient including home phone, cell phone and work phone. A signature by the responsible party is required. On an annual basis, or as needed, we will ask for a photocopy of your insurance card for your file.

*Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance carrier unless you give us your insurance information. Failure to provide us with accurate information can result in denied claims, which are then the responsibility of the patient.*

*AACI is more than happy to call and obtain benefits on your behalf as a courtesy, this is not a guarantee that the insurance company will pay the claim and/or that the benefits are quoted correct by the insurance company.*

*AACI recommends that you also call your insurance company and verify your coverage for procedures (e.g. starting Immunotherapy).*

*The patient is ultimately responsible for charges incurred regardless of the insurance involved.*

**INSURANCE CLAIMS:** I am authorizing Allergy & Asthma Care of Indiana (AACI) to furnish information to insurance carriers concerning the illness or medical treatment of myself or dependents and I hereby assign to the provider all insurance payments for medical services rendered to myself or my dependent, except for those services for which I have already paid prior to the filing of the insurance claim. In addition, I hereby designate AACI as my representative to file grievances and to represent me in accordance with the Indiana Code, title 27, Chapters 8 and 13. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in the responsibility.

***Primary Insurance:*** Allergy & Asthma Care of Indiana (AACI) will file your medical claim upon proof of insurance; (i.e., insurance card). As part of your insurance contract, full payment for ***“your part”*** of the charges is expected from you at the time of service. ***“Your part” of charges incurred is defined as any co-pays, deductibles or non-covered service charges that are incurred on the date of service.*** Come prepared to pay your co-pay at the time of service. If the patient has insurance coverage but cannot provide documentation, payment is due in full at the time of service.

Please be aware that some, and in rare cases all, of the services provided *may* be non-covered services and not considered payable under your insurance plan. **You need to contact your insurance carrier prior to your appointment for your coverage benefits.** If your insurance carrier requires you to obtain a referral for any office visits, you are responsible for obtaining that referral. If no referral is obtained and/or services rendered are not covered for any other reason, you are still responsible for the payment. We may at times assist in this process, but the full responsibility remains with the patient or responsible party.

***Secondary Insurance:*** Claims will be filed with secondary insurance if adequate information is received at the time of service.

**PATIENT FINANCIAL RESPONSIBILITY:** If no insurance is to be filed by AACI, or if AACI is not a participating provider in your insurance network, and you do not have out-of-network benefits, **full payment is due at the time of service unless other arrangements have been made. If you receive injections and need new vials, your previous vials will need to be paid in full for new vials to be mixed. Please be prepared to pay any co-insurance/co-pays/deductible at the time of each injection. OVER**

A finance charge of 1% (monthly) may be applied to any balance unpaid after 60 days of receipt of insurance payment.

**MINORS/DEPENDENTS:** Children under the age of 18 will require the signature of a responsible adult party on the registration form. An adult is required to accompany children under the age of 18 to all office visits.

**METHOD OF PAYMENT:** Acceptable methods of payment are cash, check, Visa, Discover, and MasterCard. Visa, Discover, and MasterCard will be accepted by phone or fax. Any returned check will result in an additional fee of \$25.

**ACCOUNTS PAST DUE:** Payment is due upon receipt of each statement. Non-compliance may result in preparation of account for small claims court, collection agency, and/or credit bureau reporting and possible discharge from the practice.

In the event an account is turned over for collection, the person financially responsible for the account will be responsible for the cost of collections, which includes, but is not limited to, late fees, collection agency fees, court costs, interest, and fines.

A patient may remit in full to the collection agency all outstanding charges owed on account and include amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

**CONFIRMATION OF APPOINTMENTS:** AACI will usually call you to confirm your office appointment. We will leave a message on your voice mail or with a family member if you are unavailable. This is a courtesy reminder only, and you are still responsible for missed appointments even if a reminder call is not made.

**MISSED APPOINTMENTS:** Appointments missed and not cancelled prior to 24 hours will be charged a “no show” fee of \$25.00. If a **New Patient** misses their appointment and did not cancel prior to 24 hours, no additional appointments will be made. If an established patient misses and/or cancels with less than 24 hours notice four (4) times, the patient may be discharged from the practice.

**ACCOUNT CONSULTATION:** Our account representative will be happy to discuss your account. If further assistance is needed, our Practice Manager, can be consulted as well.

**MEDICAL RECORDS:** If you require copy of your records or would like us to transfer your records to another allergist, there will be a \$10.00 administrative fee for copying the first 10 pages and .50 for each page thereafter. There may be an additional charge for postage or faxing records. This fee must be paid prior to the transfer of the records. You will also be asked to sign an authorization form for the transfer of records. Should we refer you to another physician; copies of your records will be provided to them at no cost.

**DIVORCE DECREES:** This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Your signature below indicates that you accept and understand this policy. Further, your signature authorizes AACI, to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to AACI when an assigned claim is filed.

I have received a copy of the AACI financial policy.

\_\_\_\_\_  
Print Patient's Name  
Revised 8/16

\_\_\_\_\_  
Signature (patient or responsible party)

\_\_\_\_\_  
Date





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Treating patients of all ages

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### Acknowledgement of Receipt of the Notice of Privacy Practices

This is to acknowledge my receipt of this facility's Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Name/Relationship of Personal Representative (if applicable)

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Personal representative's signature

\_\_\_\_\_  
Date

If mailing to individual:

Date mailed: \_\_\_\_\_

Address mailed to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_