ALLERGY PARTNERS

PATIENT REGISTRATION FORM

First _____ MI_____ Last_____ Pt.ID #_____

Prefers to be called_____ Date of Birth ____/_____/_____ Age ____ Marital Status: _____
Married/ Single/Divorced/Widowed/Other

Address Primary _____ City _____ State_____ Zip _____

Alternate Address _____ City _____ State_____ Zip _____

Phone #1 _____ Phone #2 _____ Phone #3 _____
Home/Cell/ Work Home/Cell/ Work Home/Cell/ Work

Email address _____ Preferred method of contact: Letter Phone call Email Other_____

Sex____ SS # _____Referring Physician _____Primary Care Physician_____
M F

Preferred Language _____ Race: _____Ethnicity: _____
Non-Hispanic or Latino/ Hispanic or Latino/ other or Undetermined

Referred by: Physician Self Family/Friend Internet Yellow pages Radio TV Other _____

Occupation_____Employer_____Is this visit related to a work injury? Y N

Current Pharmacy Name and Location _____

Emergency Contact

Name _____ Phone # _____ Relationship to patient_____

Responsible Party/Guardian/Guarantor **Address Same as Patient** ☐

Name_____ Address_____ _____ City_____ State ___ __Zip_____

Home# _____ Cell # _____ Business # _____

SS#_____ Patient's Relationship to Guarantor_____ DOB ____/____/____ ____

Sex _____ Occupation_____ Employer _____

Primary Insurance Information **Address Same as Patient** ☐

Name of Ins.Co. _____ ID # _____Group #_____Group Name_____

Policy Holder Name _____DOB ____/____/_____Relationship to Patient _____ _____

Address_____ ___ City_____ State_____ Zip_____ Phone #_____

SS# _____ Sex_____ Occupation_____ Employer _____

Secondary Insurance Information **Address Same as Patient** ☐

Name of Ins.Co. _____ ID # _____Group #_____Group Name_____

Policy Holder Name _____ DOB ____/____/_____Relationship to Patient_____

Address_____City_____ State. _____Zip_____Phone# _____

SS# _____Sex_____Occupation_____Employer_____

Financial Authorization

We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company requires an authorization or referral, it is the patient's responsibility to obtain this for the initial visit and for continuation of care.

I hereby authorize the office of Allergy Partners to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payor to pay directly to Allergy Partners for services rendered. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered.

Print Name/Signature _____Date_____
Print Name / Signature Patient/Parent/Guardian

ALLERGY PARTNERS

RECEIPT OF HIPAA NOTICE AND DESIGNATED COMMUNICATIONS

Patient Full Name: _____ **Date of Birth:** _____

I. ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the practice's Notice of Privacy Practices and have thereby been notified of how my protected health information (PHI) may be used and/or disclosed, and of my rights and the practice's legal obligations with respect to my PHI. I understand that I may contact the Allergy Partners Department of Compliance & Privacy as designated on the notice if I have a question or complaint.

_____ _____ _____

Print Name Signature Date

Relationship to Patient (Please select one) Self ☐ Parent ☐ Legal Guardian ☐

If no signature is provided above, Allergy Partners staff will make a good faith effort to obtain acknowledgment of receipt of Allergy Partners Notice of Privacy Practices at the first visit.

II. DESIGNATED COMMUNICATIONS

Messages: I understand that it may be necessary from time to time for Allergy Partners to leave messages when they are unable to reach me. I wish to be contacted as follows: (Please designate preferred number to call)

		YES	NO
Cell/Mobile telephone _____	Leave message with confirmation of appointment or call back only.	☐	☐
	Leave message with results, detailed information.	☐	☐
	Send appointment reminders via text message.	☐	☐
Home telephone _____	Leave message with confirmation of appointment or call back only.	☐	☐
	Leave message with results, detailed information.	☐	☐
Work telephone _____	Leave message with confirmation of appointment or call back only.	☐	☐
	Leave message with results, detailed information.	☐	☐

Preferred number to call: Cell/Mobile ☐ Home ☐ Work ☐

Family Members/Parents*/Friends: Allergy Partners may share my protected health information with the following designated individuals:

Print Name_____ Relationship_____

Print Name_____ Relationship_____

*Patients aged 18 years and older: Please note that we cannot discuss your healthcare, insurance or payment with your parents/others unless you fill out the appropriate information above.

I may revoke my designations above in writing by completing a new Receipt of HIPAA Notice and Designation of Authorized Communications form except to the extent that the practice has already made disclosures in reliance upon my prior designations.

_____ _____ _____

Print Name Signature Date

Relationship to Patient (Please select one) Self ☐ Parent ☐ Legal Guardian ☐

For special requests to identify specific person(s) not authorized to receive PHI, speak directly with the Practice Manager.

ALLERGY PARTNERS

MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____

Past Medical History:
(check any of the following which you have now or have been treated for in the past)

☐ ADD	☐ Chronic Sinusitis	☐ GERD/Reflux	☐ Liver Disease
☐ Alcoholism	☐ Chronic Pansinusitus	☐ Heart Disease	☐ Migraines
☐ Anemia	☐ Congestive Heart Failure	☐ Hypertension	☐ Skin Cancer
☐ Anxiety	☐ COPD	☐ Hypothyroidism	☐ Other Cancer
☐ Arthritis	☐ Depression	☐ IBD	☐ Prostate Disorder
☐ Asthma	☐ Diabetes	☐ IBS	☐ Sleep Apnea
☐ Chronic Hives	☐ Eczema	☐ Immune Deficiency	☐ Thyroid Disease
☐ Chronic Rhinitis	☐ Food Allergies	☐ Kidney Disease	☐ Tuberculosis

Surgery History:

☐ Adenoidectomy	☐ Appendectomy	☐ CABG (heart bypass)
☐ Gallbladder (Cholecystectomy)	☐ Colon Resection	☐ C- section
☐ Deviated Septum	☐ Ear tubes	☐ Hernia Repair
☐ Hip/Knee Surgery	☐ Hysterectomy	☐ Organ Transplant
☐ Pacemaker	☐ Sinus Surgery	☐ Tonsillectomy & Adenoidectomy
☐ Tonsillectomy	☐ Thyroid Surgery	Other_____

Family History: (Immediate family only Mother, Father, Sibling or Children)

	Mother	Father	Sibling	Patient's children
No Problems				
Unknown History				
Allergies				
Asthma				
Anaphylaxis				
Cystic Fibrosis				
Eczema				
Food Allergies				
Heart Disease				
Hives				
Hypertension (high blood pressure)				
Hyperlipidemia (high cholesterol)				
Immune Deficiency				
Infections, recurring				
Psychiatric Disorder				
Swelling				
Venom Allergies				

Social History ***(13 years of age and older)***

marital status: ☐ single ☐ divorced/separated ☐ married ☐ widow(er)
smoking status: ☐ current every day smoker ☐ current some day smoker ☐ former smoker
☐ never smoker ☐ unknown if ever smoked
☐ cigarettes _____ packs per day ☐ cigars _____# per day ☐ smokeless/chew _____tins per day
smoking duration: ☐n/a ☐1-5 years ☐6-10 years ☐ 11-20 years ☐over 20 years year started: _____
maximum packs per day: ☐½ ☐1 ☐1 ½ ☐2 or more
passive cigarette exposure: ☐home ☐secondary ☐home ☐other ☐none
readiness to quit: ☐ very ready ☐ somewhat ready ☐ not ready ☐ relapsed ☐ not willing to quit target quit date:_____
occupation:_____ work location: ☐indoors ☐outdoor
caffeine intake (per day) ☐ 0 ☐ 1/2 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+
alcohol intake ☐ never ☐ rarely ☐ weekly ☐ daily ☐ socially
hobbies:_____

Pediatric patients only

attends ☐school ☐daycare (name of school/daycare) _____

does child have siblings? ☐yes ☐no if yes, how many _____

child was born ☐premature ☐full term

delivery type ☐vaginal ☐C-section

complicated labor and delivery ☐yes ☐no

prolonged hospitalization as newborn ☐yes ☐no

breast fed ☐yes ☐no

feeding difficulties ☐yes ☐no

severe infections ☐yes ☐no

LATE on immunizations ☐yes ☐no

Abnormal growth and development ☐yes ☐no

ALLERGY PARTNERS

MEDICATION FORM

Name:_____ Date of Birth:_____

Current Medications and Supplements
(include milligram and number of times per day)

Medication Name	Strength	Times per Day	Taking This for What Diagnosis?

Allergies to Medications

Name of Medication	Reaction *(hives, throat swelling, other reactions)*

☐ **NO KNOWN DRUG ALLERGIES**

When was your last flu shot?_____

When was your last pneumonia shot?_____

Preferred Pharmacy:
(Name) _____
(Street Address) _____
(City, State, ZIP Code) _____
(Telephone Number) _____
(Fax Number) _____

ALLERGY PARTNERS

REVIEW OF SYSTEMS / ENVIRONMENTAL HISTORY

Name:_____ Date of Birth:_____

Reason for today's visit: _____

*Do you **CURRENTLY HAVE ONGOING /RECURRING PROBLEMS** with any of the following:*

General	Nose	Respiratory	Skin
☐ no problem	☐ no problems	☐ no problems	☐ no problems
☐ poor weight gain	☐ nasal congestion	☐ cough	☐ swelling
☐ fevers	☐ clear nasal drainage	☐ chest tightness	☐ dryness
☐ chills	☐ colored nasal drainage	☐ coughing up blood	☐ hives
☐ sweats	☐ post nasal drip	☐ daytime sleepiness	☐ itching
☐ poor appetite	☐ nosebleeds	☐ shortness of breath	☐ rash
☐ fatigue	☐ itching	☐ snoring	☐ eczema
☐ malaise	☐ sneezing	☐wheezing	
☐ weight loss	☐ sinus pressure/pain	☐difficulty with exercise	**Neurologic**
			☐ no problems
Eyes	**Throat**	**Gastrointestinal**	☐ headaches
☐ no problems	☐ no problems	☐ no problems	☐ weakness
☐ blurring	☐ hoarseness	☐ heartburn	☐ seizures
☐ discharge	☐ difficulty swallowing	☐ nausea	☐ passing out
☐ eye pain	☐ sore throat	☐ vomiting	☐ dizziness
☐ itchy	☐ oral ulcers	☐ diarrhea	
☐ red	☐ throat clearing	☐ constipation	**Mental Health**
☐ vision loss	☐ itching	☐ abdominal pain	☐ no problems
☐ watery		☐ bloody stool	☐ depression
☐ dry	**Cardiovascular**	☐ jaundice	☐ anxiety
	☐ no problems		☐ hyperactivity problem
Ears	☐ chest pains	**Musculoskeletal**	☐ behavior problems
☐ no problem	☐ palpitations	☐ no problems	
☐ earache	☐ passing out	☐ back pain	**Allergic /Immunologic**
☐ ear discharge	☐ peripheral edema	☐ joint pain	☐ no problems
☐ ringing in the ears	☐ shortness of breath lying down flat	☐ joint swelling	☐ recurring infections
☐ decreased hearing		☐ stiffness	☐ venom sting reaction
☐ ears popping			☐ latex reaction
☐ room spinning around			☐ food reaction
☐ itching			☐ drug reaction

Housing	Foundation	Air Conditioning	Heating
☐ house	☐ basement	☐ none	☐ none
☐ apartment/condo	☐ crawlspace	☐ window units	☐ wood stove
☐ mobile/ manufactured home	☐ slab	☐ central	☐ central hot air
		☐ evaporative cooler	☐ kerosene
			☐ electric space heater
			☐ natural gas

Indoor Mold	Water Damage	Pests	Smoke Exposure	Bedroom
☐ none	☐ none	☐ none	☐ none	☐ carpet
☐ AC vents	☐ leaky roof	☐ roaches	☐ parents	☐ ceiling fan
☐ bathroom	☐ plumbing problems	☐ rodents	☐ spouse/partner	☐ humidifier
☐ window frames	☐ musty odors		☐ grandparent	☐ sleeps in own bed
☐ walls	☐condensation		☐ caretaker	☐ shares bed
☐ basement	☐ water stains		☐ other	

Bed	Outdoor Environment	Pets	How Many?
☐ crib mattress	☐ none	☐ none	Dog Inside:
☐ standard mattress	☐ cattle	☐ dogs	Dog Outside:
☐ water bed	☐ chickens	☐ cats	Cat Inside:
☐ down pillow/ comforter	☐ horses	☐ birds	Cat Outside:
☐ dust ruffle	☐ goats	☐ hamsters	
☐ stuffed toys	☐ farm	☐ gerbils	
☐ wool blanket		☐ rabbits	
☐ allergy pillow cover		☐ guinea pigs	
☐ allergy mattress cover		☐ other	
☐ pets sleeps in bed			

ALLERGY PARTNERS

MEDICATION SUSPENSION FOR TESTING

Some Medications can interfere with allergy skin testing. In order for us to obtain the most accurate results, **please stop antihistamines used for allergy treatment 5 days prior to New Patient Appointments** and prior to Skin Testing. If you have a question about whether it is safe for you to stop your antihistamine, please contact your prescribing physician.

COMMON MEDICATIONS CONTAINING ANTIHISTAMINES INCLUDE:

Sedating Allergy Medications (All Forms)

Advil Allergy	Carbinoxamine	Extendryl
Alahist	Chlorpheniramine	Ketotifen
AlleRX	Clor-Trimeton	Palgic
Allergy Relief Medication	Diphenhydramine (Benadryl)	Polyhistine
Brompheniramine (Bromfed)	Doxylamine	Tylenol Allergy
Clor-Trimeton		

Non-Sedating Allergy Medications (All Forms)

Cetirizine (Zyrtec, Wal-Zyr)	Fexofenadine (Allegra)	Loratadine (Claritin, Alavert)
Desloratidine (Clarinex) - **None x 7 days**		
Levocetirizine (Xyzal) - **None x 7 days**		

Nasal Sprays

Azelastine (Astelin, Astepro)	Dymista	Olopatadine (Patanase)

Cough/Cold /Sinus Remedies

Actifed	Dimetane	Semprex-D
Advil Cold/Sinus	Dimetapp	Sinutab
Aleve Cold	Drixoral	Sudafed Cold + Allergy
Alka Seltzer Plus/Cold	Norel SR/MD	Tanafed
Allerest	Nyquil	Theraflu (All forms)
BC Cold Powder	Pediacare	Time Hist
Benylin Cough	Percogesic	Triaminic (All forms)
Comtrex	Phenyltoloxamine	Tussionex
Contac	Robitussin (many forms)	Tylenol Cold+Sinus
Coricidin	Rondec	Vicks 44 M
Co-Tylenol	Rynatan/R-Tannate	Zicam

Sleep Aids

Advil PM	Doxylamine	Nytol
Alertec (Modafinil)	Excedrin PM	Sominex
Hydroxyzine (Atarax/Vistaril)	Night Time Sleep Aid	Tylenol PM/Tylenol Sleep
Doxepin (Sinequan)		

Anti-Nausea/Vertigo Medications

Chlorpromazine	Prochlorperazine (Compazine)
Dimenhydrinate (Dramamine)	Promethazine (Phenergan)
Meclizine (Antivert)	

Stomach Acid Medications

Cimetidine (Tagamet)	Famotidine (Pepcid, Mylanta AR)	Ranitidine (Zantac)

Itch Relief Medications

Cyproheptadine (Periactin)	Doxepin (Sinequan)	Hydroxyzine (Atarax/Vistaril)
Diphenhydramine (Benadryl)		

Others

Cyclobenzaprine (Flexeril)

Do not use oil, cream or lotion on your back or arms for 24 hours prior to skin testing.

Please continue taking all of the following medications as prescribed:

- Antibiotics
- Antidepressants
- Asthma Medications- All
- Blood Pressure Medications
- Decongestants
- Heart Medications
- Inhalers
- Nasal Sprays- **Except** Astelin/Astepro/Patanase
- Steroids
- Thyroid Medications

Do not stop these medications without the approval of your physician.

Please call your local Allergy Partners office with any questions about these lists.

ALLERGY PARTNERS

FINANCIAL POLICY

Name:_____ Date of Birth:_____

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies or your insurance coverage and your financial responsibilities

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education and training and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

Patient Payments: Co-pays, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. Payments may be made with cash, check or credit card. Returned checks will be subject to the fee allowed by state regulations. Please let us know if you are having a particular financial problem and we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our in house Financial Coordinator or our Central Billing Office.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company requires an authorization or referral, it is the patient's responsibility to obtain this for the initial visit and for continuation of care.

Additional Fees:

Missed Appointments: Please understand that when you reserve an appointment with one of our physicians, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. To assist all of our patients with appropriate access to our physicians we may charge a fee for any office visit appointment cancelled with less than 24 hours' notice. Please note this fee is not covered by your insurance company.

Medical Supplies: Please note that certain medical supplies given to you at your visit require an advanced payment from you at check out. We will submit any charges for medical supplies to your insurance company, and we will reimburse you the payment difference made by your insurance company.

Medical Forms: The completion of disability forms, attending physician statements and other supplemental insurance forms all require physician and staff time to complete. Accordingly, a fee may be charged to complete most of these forms. Non-standard forms may be higher.

Nurse Visit: Please note that if a patient comes in without an appointment to speak to a nurse, depending on the time and complexity of the visit, there may be a charge for the visit.

Print Name/Signature _____Date_____

Print Name / Signature Patient/Parent/Guardian

ALLERGY PARTNERS
Leaders in Allergy & Asthma Care

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.

This Notice of Privacy Practices (the "Notice") describes the privacy practices of Allergy Partners of California, Inc.

Protected health information (PHI) is information, including demographic data, that that can be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the past, present or future payment for the provision of your health care.

We understand the importance of privacy and are committed to maintaining the confidentiality of your PHI. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of PHI, to provide individuals with notice of our legal duties and privacy practices with respect to PHI, inform you of your rights and the ways we may use PHI and disclose it to others; and to notify affected individuals following a breach of unsecured PHI. This Notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Department of Compliance & Privacy using the information at the end of this Notice.

A. How We May Use or Disclose Your PHI

We may use or disclose your PHI for the following purposes:

1. Treatment. We may use your PHI and share it with other professionals who are treating you. For example, we may share your PHI with other physicians or other health care providers who will provide services that we do not provide. Or we may share PHI with a pharmacist who needs it to dispense a prescription to you, or with a laboratory that performs a test. We may also disclose PHI to members of your family or others who can help you when you are sick.

2. Payment. We may use and disclose your PHI to obtain payment for the services we provide. For example, we may give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose your PHI to operate our medical practice, improve your care, and contact you when necessary. For example, we may use and disclose PHI to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose PHI as necessary for medical reviews, legal services and audits, including fraud and abuse detection, compliance programs, business planning and management. We may also share your PHI with our "business associates" that perform services for us. We have a written contract

with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your PHI. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with certain operational activities permitted under the law.

4. Notification and Communication with Family. We may disclose your PHI to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose PHI to a relief organization so that they may coordinate these notification efforts. We may also disclose PHI to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will make an effort to give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

5. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your PHI for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

6. Sale of Health Information. We will not sell your PHI without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

7. Fundraising. We may contact you for fundraising efforts, but you can tell us not to contact you again.

8. Required by Law. As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law, to disclose your PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your PHI to health oversight agencies during audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your Health Information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your PHI to coroners or medical examiners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your PHI to organizations involved in procuring, banking or transplanting organs and tissues.

15. Research. We may use and disclose your PHI for research purposes. Your medical record may be reviewed, and data included in a research study in compliance with federal and state laws. Your PHI may be reviewed in preparation for research or to notify you about research studies in which your provider may consider you a candidate or which you may have interest. In some cases, PHI may be used or disclosed for research, and no additional authorization is required from you. In some cases, an Institutional Review Board (IRB) or its designee may determine whether your authorization is necessary for your PHI to be used or disclosed for research purposes. If required, your written authorization will be requested, and you will only become a part of one of these research projects if you agree to do so and sign an authorization.

16. Public Safety. We may, and are sometimes required by law, to disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Specialized Government Functions. We may disclose your PHI for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Workers' Compensation. We may disclose your PHI for Workers' Compensation or other similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

19. Breach Notification. In the case of a breach of unsecured PHI, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. Other Uses or Discloses of Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose your PHI without your written authorization. If you do authorize this medical practice to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. You must make your request in writing and tell us what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply, for example, only to you and your spouse. If you tell us not to disclose information to your health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your PHI in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Access. You have the right to inspect and receive a copy your PHI, with limited exceptions, for as long as we maintain the PHI. To access your PHI, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, we will provide in your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. As permitted by law, we will charge a reasonable fee for providing a copy of your PHI which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary.

   We may deny your request without providing you an opportunity for review under limited circumstances. In other circumstances, we may deny your request provided we give you the right to have such denials reviewed.

4. Right to Amend or Supplement. You have a right to request that we amend your PHI that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your PHI, and if we deny your request, will provide you with information about this medical practice's denial and how you can disagree with the denial.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your PHI made by this medical practice.

6. Right to a Paper Copy of this Notice. You have a right to a paper copy of this Notice at any time, even if you have previously requested the Notice electronically.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Department of Compliance & Privacy using information is at the bottom of this Notice.

D. Changes to this Notice of Privacy Practices

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

E. Complaints

You can complain If you feel we have violated your rights by contacting our Department of Compliance & Privacy using the information below. You can file a complaint with the Secretary of the United States Department of Health and Human Services Office for Civil Rights.

We will not retaliate against you for filing a complaint.

Department of Compliance & Privacy
Allergy Partners
1978 Hendersonville Road
Asheville, NC 28803
(T) (844) 744-9509
Email: compliance@allergypartners.com

This Notice is effective October 1, 2021.