Relief
Allergy & Sinus Institute

(630) 513-1691
reliefasi.com

Patient Registration Form

First _____ MI _____ Last _____

Pt.ID # _____ Date of Birth _____ Marital Status _____

Address Primary _____ City _____ State _____ Zip _____

Phone _____ Phone _____ Email _____
Cell Home

How may we contact you?: ❑ Letter ❑ Phone call ❑ Email ❑ Other _____

Sex _____ SS # _____ Referring Physician _____

Primary Care Physician _____ Please send a letter to my doctor: ❑ Yes ❑ No

Race Code _____ Ethnicity Code _____ Primary Language _____
Please refer to the "Meaningful Use Race and Ethnicity Guide" when indicating your Race and Ethnicity.

Referred by: ❑ Self ❑ Physician ❑ Internet ❑ Radio ❑ Family/Friend ❑ Television ❑ Other _____

Employer _____ Occupation _____

Is this visit related to a work injury?: ❑ Yes ❑ No

Preferred 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 # _____

Patient's Relationship to Guarantor _____ DOB _____ Sex _____

Employer _____ Occupation _____

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Primary Insurance Information

Name of Ins. Co. _____ ID # _____ Group # _____ Group Name _____

Policy Holder Name _____ DOB _____ Relationship to Patient _____

Phone # _____ Address _____

City _____ State _____ Zip _____

SS # _____ Sex _____ Employer _____ Occupation _____

Secondary Insurance Information

Name of Ins. Co. _____ ID # _____ Group # _____ Group Name _____

Policy Holder Name _____ DOB _____ Relationship to Patient _____

Phone # _____ Address _____

City _____ State _____ Zip _____

SS # _____ Sex _____ Employer _____ Occupation _____

Financial Authorization

I hereby assign, transfer and set over to Allergy & Asthma Medical Associates, Ltd. dba Relief Allergy & Sinus Institute (the "Practice") all my rights, title, and interest in my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. (Charges may include any service charges, collections fees, late fees and bad check handling charges). You will be required to also sign our Patient Financial Responsibility Agreement which outlines further financial responsibilities.

I understand that presenting myself (or my legal guardian) for health care services at the Practice, I authorize and consent to the performance of all tests, treatments and procedures which may be ordered by my physician(s) or providers and I consent for such treatments and procedures to be carried out by members of the medical and nursing staff at the Practice.

Print Name/Signature _____ Date _____
Print Name/Signature Patient/Parent/Guardian

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Notice of Privacy Practices – Patient Receipt

Print Name of Patient: _____ Date of Birth: _____

I acknowledge I have received Relief Allergy & Sinus Institute's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information (PHI) that may be made by this practice.

I understand that Relief reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain Relief's current Notice of Privacy Practices upon request.

Our receptionists will be calling or texting you with appointment reminders. Additionally, the physicians and nursing staff often need to speak with you regarding medical issues and/or prescriptions. Please assist our staff by designating how you prefer to be contacted:

- ❑ Home
- ❑ Work
- ❑ Cell Phone # _____
- ❑ Home Answering Machine
- ❑ Work Voice Mail
- ❑ Other (Please specify) _____

I authorize you to leave messages as indicated:

- ❑ All pertinent information
- ❑ Leave only a request to call back, referencing the office phone number

I authorize you to use or disclose my health information (PHI) for purposes of continued care to the following:

- ❑ Parent(s) or Guardian (Name) _____
- ❑ Spouse, Relative or other (please specify by name and relationship)

_____

If patient is of school age, I authorize you to fax PHI to his/her school nurse as indicated:

- ❑ Upon my request only
- ❑ In response to fax received from school with parent signature
- ❑ In response to fax received from school without parent signature

Signature: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

For Office Use Only
An attempt was made to obtain a signature of receipt of the Relief Notice of Privacy Practices. This was unsuccessful and is documented below:

Date: _____ By: _____

Reason: _____

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Patient Financial Responsibility Agreement

Your signature below forms a binding agreement between, on the one hand, Allergy Asthma Medical Associates, LTD. dba Relief Allergy & Sinus Institute (the "Practice") and, on the other hand, the undersigned Patient who is receiving medical services or the undersigned Responsible Party for patients under 18 years old or holding other legal representative status. The Responsible Party is the individual who is financially responsible for payment of medical bills. This includes all fees for medical visits, procedures, and tele-health communications.

Co-Pays, Deductibles and Co-Insurance:
All co-pays must be paid at the time of service. All charges for services rendered are due and payable in full. Insurance coverage is part of a contract agreement between you and your insurance company. All charges will be submitted to your insurance company on your behalf. Any amounts that are not covered by your insurance, such as coinsurance, deductibles or an uncovered service, will be your financial responsibility. You hereby waive any and all claims against the Practice with respect to processing of insurance claims and the payment of benefits from the insurance company to you. Acceptable payment methods include cash, credit card or check.

Self-Pay Patients:
If you do not have health care coverage and still wish to see our providers, you will be considered self-pay. Our services will be offered at a discounted rate. Payment in full may be due at the time of service unless you make other arrangements with our billing department. Please reach out to our billing department for self-pay solutions, billing@reliefasi.com.

Returned Check Policy:
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $35.00 check service charge. Once notice is received of the returned check, Practice will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $35.00 check service charge.

Missed Appointments and Late Cancellations:
You will be charged a fee of **$75.00** if you miss an appointment or fail to cancel an appointment at least 24 hours prior to your scheduled visit. If you fail to appear for your appointment within 20 minutes after the scheduled time, the appointment will be considered missed without appropriate cancellation and you will be subject to a fee of $75.00. You must pay this balance in full at the time of your next appointment.

Non-Payment on Account:
Should collection proceedings or other legal action become necessary to collect an overdue account and missed appointments/late cancellations, the Patient or the Patient's Responsible Party understands that Practice has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at a 18% per annum (or the highest rate permitted by law, if lesser), all court costs and attorneys' fees, and collection fees, which will be added to the outstanding balance.

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By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party. Your signature verifies that you have read this Patient Financial Responsibility statement, understand your responsibilities, and agree to these terms. A photocopy of this document shall be as effective and valid as the original.

_____ _____
Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ _____
Signature of Patient/Responsible Party (Representative Status) Date of Signature

If the above person is the legal representative of the patient, please write the patient's name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.

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Effective Date: January 1, 2022

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. Relief Allergy & Sinus Institute is required to abide by the terms of the Notice of Privacy Practices (NPP) currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information (PHI). If you have any questions about this Notice, please contact the Privacy Official of our practice.

Who Will Follow This Notice

Any health professional authorized to enter information into your medical record, all employees, staff and other personnel at practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations as described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment. We may use medical information (PHI) about you to provide you with medical treatment or services. Example: we may use and disclose PHI when you need a prescription, lab work, an x-ray, or other health care services.

For Payment. We may use and disclose medical information (PHI) about you so that treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your PHI, such as your name, address, office visit date, copy of your chart
and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information (PHI) about you for health care operations to assure that you receive quality care. Example: We may use PHI to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner or identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)

- Other healthcare providers' treatment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information
Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice ro with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request additional restrictions on the PHI that we may use or disclose for treatment, payment, and health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency. To request restrictions, you must submit your request in writing to the Privacy Official at this practice. In your request, you must tell us what information you want to restrict, how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or both), and to whom you want the restrictions to apply.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request in writing to the Privacy Official at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to request the opportunity to inspect and receive a copy of PHI about you that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and PHI to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Official at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed

health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request, you must submit your request in writing to our Privacy Official. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept of file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting on Non-Standard Disclosures. You have the right to request a list of the disclosures we made of PHI about you. To request this list, you must submit your request to the Privacy Official at our office. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). We reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of the Notice. You have the right to receive a paper copy of this Notice at any time. You are entitled to a paper copy of this Notice. To obtain a paper copy of this Notice, please contact our Privacy Official listed in this Notice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as any information we receive in the future. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you a copy of the revised Notice upon your request made to our Privacy Official.