Allergy & Asthma Associates of Southern California

Leading-edge, personalized care you can trust

27800 Medical Center Rd. Suite 244, Mission Viejo, Ca 92691
15785 Laguna Canyon Rd. Suite 100 Irvine, CA 92618
T: (949) 364-2900 F: (949) 365-0117
www. SoCalAllergy.com

What To Expect For Your New Patient Appointment

- Due to the thoroughness of your initial exam, new patient appointments typically last between 2-3 hours.

- Expect to have a number of allergy tests performed on the skin to determine what you are allergic to. **To ensure your testing is as accurate as possible please stop taking your antihistamine medications (Claritin, Zyrtec, Allegra, Benadryl, Azelastine, or their generic equivalents) 5 days prior to your appointment.**

- A strong odor can be a dangerous trigger to patients with asthma and allergies. Please do not wear perfumes or fragrant lotions when visiting our office. Also, while in our office you may not use nail polish, polish removers, glues or other items with strong odors.

- Typically, you will be provided the results of your allergy tests on the same day as your appointment.

  At the conclusion of your visit, you will be asked to schedule an appointment to return to the office in about 3-4 weeks to evaluate your progress on a selected treatment regimen.

Allergy & Asthma Associates of Southern California

PATIENT INFORMATION SHEET

Please Select One: Mrs.☐ Ms.☐ Miss☐ Mr.☐ Child☐ Single☐ Married☐ Divorced☐ Widowed☐

Patient Name:

Date of Birth Age SSN Male☐ Female☐

Home Address City,St,Zip

Home Phone Cell #

Race ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian-Alaskan Native

☐ Other Race

Ethnicity ☐ Hispanic Latino ☐ Non-Hispanic or Latino Preferred Language: ☐ English ☐ Other:

EMAIL Driver's Lic. #

Preferred Means of Communication(Please Check One): ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Mail ☐ Any

How did you hear about us? ☐Physician Name: ☐Community Event Name:

☐Flyer ☐Browsing the web ☐Friend ☐Yelp ☐Google ☐Yahoo ☐PPO Insurance Directory

FAMILY PHYSICIAN **PHYSICIAN PHONE #**

IF PATIENT IS A MINOR:

Father's Name: **Mother's Name:**

Birthday Birthday

Occupation Occupation

Employer Employer

Street Street

City,St,Zip Code City,St,Zip code

Phone # Phone #

EMERGENCY CONTACT **RELATIONSHIP** **PHONE #**

PRIMARY INSURANCE:

Ins Type: ☐ EPO ☐HMO☐PPO☐POS

Primary Insured Name D.O.B. SS#

Insured's Employer Occupation

Insurance Company Name DL #

Insurance Address Effective Date

Insurance Ph. # Relationship to Subscriber

ID # on Card Group #

SECONDARY INSURANCE:

circle: ☐ EPO ☐HMO☐PPO☐ POS

Primary Insured Name D.O.B. SS#

Insured's Employer Occupation

Insurance Company Name DL #

Insurance Address Effective Date

Insurance Ph. # Relationship to Subscriber

ID # on Card Group #

***** PLEASE READ *****

INSURANCE INFORMATION: I acknowledge that the physicians of Allergy and Asthma Assoc. may or may not be a part of the provider network for my insurance company and that it is my responsibility to verify that the providers are participating in my network. Please give your card(s) to the receptionist so we may keep a copy on file. All professional services rendered are charged to the patient/guardian. The patient is responsible for all fees regardless of insurance coverage. I hereby authorize Allergy and Asthma Assoc. to furnish all information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and that it is my responsibility to ask for an estimation of the costs of any tests being recommended/ordered prior to them being performed. My signature below indicates that I have read and agree to these said statements.

Signature: Relationship: Date:

For Opting Out Only Of Receiving Email and Text Messages Related To Appointment Reminders and Patient Care Sign Below **(Otherwise Leave Blank)**:

Signature Opting Out Email/Text Messages: Date:

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PATIENT NAME:_____ **TODAY'S DATE:**_____
DATE OF BIRTH:_____ **SEX: M☐F☐ AGE:**_____
EMAIL ADDRESS:_____ **PHONE:**_____
REFERRED BY:_____ **PCP:**_____

INSTRUCTIONS FOR COMPLETING HEALTH QUESTIONNAIRE: If you are unable to complete this form online or prefer to fill out a hard copy, please print and complete this document, bringing it with you when you arrive for your first appointment. This form is designed to help find the cause of your problem and is an essential part of your evaluation, aiding in the proper selection of tests and treatments, and allowing us to spend more time focusing on your important problems. When possible, please provide a start and stop date for all medical conditions as well as provide a check box in the Med Taken box if you are currently taking medication for that condition. If you have a condition that is not listed please add it in the OTHER section.

****PLEASE NOTE: No antihistamines, such as Claritin, Allegra, Zyrtec, or Benadryl for at <u>least 72 hours</u> before your appointment, as they interfere with allergy testing. Asthma medications are allowed if needed for wheezing and coughing. If you are unsure of any medication you are presently taking, please call our office for instructions. ****

CHIEF COMPLAINT: (The main reason you are here)

HISTORY OF PRESENT ILLNESS (Please provide a brief description of your current condition)

Please List All Current Medications	Dosages

PATIENT NAME:_____ DOB:_____

Please indicate if you have **EVER** been diagnosed with any of the medical conditions listed below

Allergies

☐ Hayfever or Allergic Rhinitis (Stuffy, Runny, Itchy Nose, Sneezing)

Symptoms Worse: ☐ Indoors ☐ Outdoors ☐ Both

☐ Allergic Conjunctivitis (Red, Itchy Eyes)

☐ Food Allergy

List Each Food and Reaction:

_____

_____

_____

☐ Stinging Insect Allergy (Bee, Wasp, Hornet, Etc.)?_____

☐ Drug Allergies

List Each Drug and Reaction:

_____

_____

Eyes, Ears, Nose & Throat

☐ Sinus Infections ☐ Ear Infections

☐ Nasal Polyps ☐ Hearing Loss

☐ Bloody Nose ☐ Cataracts

☐ Tubes in Ears ☐ Glaucoma

Lungs/Pulmonary

☐ Asthma

If yes: ☐ Have you ever used oral steroids for Asthma/COPD?

Date:_____

☐ Have you ever been hospitalized Asthma/COPD?

Date:_____

☐ # of ER visits in the past year for Asthma/COPD #_____

☐ How many times per week do you use your rescue medication?

#:_____

☐ Pneumonia Date:_____ ☐ Pulmonary Embolism Date: _____

☐ Smoking Packs/Day____ Yrs of Smoking:_____ Date Quit:_____

Skin/Dermatologic

☐ Eczema ☐ Hives Other Rash:_____

Endocrine

☐ Diabetes ☐ Thyroid Disease

☐ Other Endocrine Problems:_____

Heart/Cardiovascular

☐ High Blood Pressure ☐ High Cholesterol

☐ Heart Attack ☐ Heart Murmur

☐ Angina or Chest Pain ☐ Arrhythmias

Digestive/Gastrointestinal

☐ Ulcer ☐ Irritable Bowel

☐ Acid Reflux or Heartburn ☐ Diarrhea

☐ Nausea or Vomitting ☐ Hepatitis

Genitourinary/Gynecological

☐ Urinary Tract Infections ☐ Genital Herpes

☐ Enlarged Prostate ☐ Hysterectomy

☐ Menopause

Rheumatologic

☐ Osteoarthritis ☐ Rheumatoid Arthritis

☐ Osteoporosis ☐ Other:_____

Neurologic

☐ Migraine Headaches ☐ Sinus Headaches

☐ Stroke ☐ Seizures

☐ Other Neurologic Disorder:_____

Psychiatric

☐ Depression ☐ Anxiety

☐ Bipolar Disorder ☐ ADD/ADHD

☐ Other Psychiatric Disorder:_____

Other Chronic Medical Conditions:

PATIENT NAME:_____ DOB:_____

Cancer (Please specify type):

Surgical Procedures (List any previous surgeries and dates)

Previous Evaluation

☐ Allergy Tested Before? Date:_____

☐ Received Allergy Injections? Date:_____

☐ Pulmonary Function Testing? Date:_____

Medications that made your symptoms better:_____

Medications tried but did not help:_____

Family History (Check all that apply & the relationship)

☐ Hayfever? Relationship:_____

☐ Asthma? Relationship:_____

☐ Sinus Problems? Relationship:_____

☐ Eczema? Relationship:_____

☐ Bronchitis? Relationship:_____

☐ Emphysema? Relationship:_____

☐ Cystic Fibrosis? Relationship:_____

☐ Diabetes? Relationship:_____

☐ Heart Disease? Relationship:_____

Social History

School:_____ Grade:_____

Occupation:_____

Do you smoke? ☐ Yes ☐ No ☐ Quit

Packs Per Day?_____ How many years?_____

Exposed to second hand smoke? ☐ Yes ☐ No

Do you drink alchohol? ☐ Yes ☐ No ☐ Quit

How many drinks per week?_____

Do you drink caffeine (Coffee/Tea/Caffeinated Soda)? ☐ Yes ☐ No

Type:_____ Cups/Day:_____

Do you use any illicit drugs? ☐ Yes ☐ No ☐ Quit

Type:_____

Environmental

☐ Carpet ☐ Smokers in the home

☐ Pets (If yes, select type) ☐ Cat ☐ Dog ☐ Other:_____

Review of Systems

Please indicate any **Current** problems in the following areas:

General

☐ Chills ☐ Fever ☐ Weightloss ☐ Fatigue

Eyes

☐ Change in vision ☐ Itchy ☐ Red ☐ Watery

Ears

☐ Ear Infection ☐ Decreased Hearing ☐ Ear Popping

Nose

☐ Congestion ☐ Runny Nose ☐ Sneezing ☐ Itchy Nose

☐ Sinus Infection ☐ Post Nasal Drip ☐ Seasonal Allergies

Throat

☐ Sore Throat ☐ Change In Voice

Respiratory

☐ Shortness of Breath ☐ Cough ☐ Pain With Breathing

☐ Wheezing ☐ Problems with exercise

Cardiovascular

☐ Chest Pain ☐ Palpitations ☐ Arrythmias

☐ Leg Swelling

Gastrointestinal

☐ Abdominal Pain ☐ GERD or Acid Reflux ☐ Diarrhea

☐ Food Allergy

Reproductive

☐ Penile Discharge ☐ Vaginal Discharge ☐ Breast Pain

☐ Breast Lump ☐ Sexual Dysfunction

Skin

☐ Hives ☐ Red Rash ☐ Itchy Rash ☐ Contact Allergy

PATIENT NAME:_____ DOB:_____

Review of Systems (continued)

Neurologic	**Psychiatric**
☐ Dizziness ☐ Headache ☐ Numbness ☐ Vertigo/Room Spinning **Musculoskeletal** ☐ Back Pain ☐ Joint Pain ☐ Muscle Aches	☐ Anxiety ☐ Depression ☐ Increased Stress **Other (Please Describe):**

PLEASE NOTE: ALL INFORMATION SUBMITTED ON THIS FORM IS CONSIDERED SECURE HEALTHCARE INFORMATION AND IS HELD IN THE STRICTEST CONFIDENCE, PROTECTING YOUR RIGHTS TO PRIVACY.

QUESTIONNAIRRE COMPLETED BY:_____
RELATIONSHIP TO PATIENT:_____
DATE COMPLETED:_____

FOR OFFICE USE ONLY
This history form has been reviewed and discussed in detail with the patient.

_____ _____
Physician Signature Date

ALLERGY & ASTHMA ASSOCIATES

FINANCIAL POLICY

We appreciate the confidence that you have expressed in selecting us as your physicians, and we are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. If you have any questions about our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

Payment in full is required at the time of service for:

1. Patients without insurance (self-pay)
2. Patients who are not covered by one of our contracted insurance plans.
3. Patients who do not provide us with contracted insurance information
4. Patients with outstanding balances owed for co-pays, and deductibles
5. Any non-covered services

ALL COPAYS ARE DUE AT THE TIME OF SERVICE

Co-Payment and Deductible
You are responsible for your deductible/coinsurance and co-payment. If you have questions or concerns regarding your out-of-pocket costs for any procedures or exams, please inquire of these costs from the Billing Department prior to these services being performed. The Billing Department will be happy to provide an estimate for the cost of services upon request at each visit for the costs that the patient will incur. Any statement of coverage/benefits from staff from any other department will not be considered valid. A lack of understanding on the part of the patient in what or how much their insurance covers or whether the tests/procedures are subject to their deductible does not waive their financial responsibility. ***The decision by the financially responsible party to refrain from inquiring with the Billing Department about the costs of services prior to them being performed is to be understood as meaning that the financially responsible party is satisfied with the out-of-pocket costs involved for said services should any be incurred.*** Your initials below indicate your acknowledgement and agreement to the above information.

_____Initials

We accept cash, personal checks, Visa & MasterCard
For Medicare & contracted insurance plans, we will bill all services at no charge as per the requirements of the insurance contract.

All returned checks may be subject to a $20.00 service charge. You may be responsible for other costs of collection as permitted by law.

If the patient is a minor (under 18 years of age and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined above.

It is your responsibility to obtain any required referrals for treatment at, or prior to, the time of service. Patients seen or treated in our office, without prior authorization from their HMO group, are responsible for the full charge of the visit. If you need to use a specific lab or x-ray facility, you must notify the nurse before the service is rendered.

Services rendered by this office that are not a covered benefit or extend past the allotted quantity for a given visit or procedure by your insurance policy will be the patient's financial responsibility.

Our office staff will assist you in working with your insurance carrier, but it is the patient's financial responsibility to contact their insurance company and understand their own insurance plans, the amount of covered benefits the insurance company provides and if needed, to ask for a quote of the estimated cost services ***prior*** to them being rendered.

I authorize my insurance benefits to be paid directly to Allergy & Asthma Associates.
I authorize Allergy & Asthma to release any medical or other information to my insurance company if requested.

"NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov. "
I understand that my signature below confirms that I have read, understand and agree to the policies described above.

_____
Signature & Date

Print Patient's Name_____

Revised 12/05/2018

Allergy & Asthma Associates of Southern California

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Auto Payment Authorization Form

Schedule your payment to be automatically charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Automatic Payments Will Make Your Life Easier:

- It's very convenient! Setup takes less than 5 minutes.
- Saves time by eliminating the need to write a check each month

Here's How Automatic Payments Work:

You authorize regularly scheduled charges to your credit card. On the 15th of each month, after your insurance has processed the claim and determined the patient's financial obligation, your credit card will be charged the corresponding amount. This is the same amount that will be the amount on your statement. A receipt for each payment will be emailed to you and the charge will appear on your credit card statement. To ensure the security of your information we have partnered with Authorize.Net, a leading and trusted provider of credit card processing, to store and maintain your data. Lastly, by signing below you agree that no prior-notification will be provided.

☐ **Agree**

☐ **Declined**

Reason:_____

If you agree with this, please complete the information below:

Automatic Payments (also called Credit Card on File): Your credit card will be charged on the 15th of each month the amount of the remaining patient responsibility after your insurance has processed the claim and determined the patient's financial obligation.

I _____ authorize **Allergy & Asthma Associates of Southern California** to
(Full Name)
charge my credit card without prior notification for (Patient's Full Name)_____.

_____(Please Initial) I understand that credit card on file transactions will be charged on the 15th or soonest business thereafter the balance of the amount reflected on the patient's monthly statement.

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Allergy & Asthma Associates of Southern California** in writing of any changes in my account information or termination of this authorization at least 30 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

ALLERGY & ASTHMA ASSOCIATES OF SOUTHERN CALIFORNIA

"NOTICE TO CONSUMERS: MEDICAL DOCTORS (M.D.) ARE LICENSED AND REGULATED BY THE MEDICAL BOARDS OF CALIFORNIA. (800) 633-2322, www.mbc.ca.gov"

Warner W. Carr, MD, CA Med License #A98901
Board Certified in Internal Medicine and Allergy & Immunology

Mark S. Sugar, MD, CA Med License #C32628
Board Certified in Pediatrics and Allergy & Immunology

Vinay Mehta, MD, CA Med License #181294
Board Certified in Physician & Surgeon and Allergy & Immunology

"NOTICE TO CONSUMERS: OSTEOPATHIC PHYSICIANS AND SURGEONS (D.O.) ARE LICENSED AND REGULATED BY THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA. (916) 928-8390, www.ombc.ca.gov"

Christine Y. Lee-Kim, DO, CA Med License# 20A11915
Board Certified in Internal Medicine and Allergy & Immunology
Osteopathic Medical Board of California

"NOTICE TO CONSUMERS: NURSE PRACTITIONERS (FNP-C) ARE LICENSED AND REGULATED BY THE BOARD OF REGISTERED NURSE. (916) 322-3350, www.rn.ca.gov"

Cheryl Carr, FNP-C, CA License #3392 & License #718185

Austin Moore McPhee, FNP-C, CA License #95018709

"NOTICE TO CONSUMERS: PHYSICIAN ASSISTANTS (PA) ARE LICENSED AND REGULATED BY THE PHYSICIANS ASSISTANTS COMMITTEE. (916) 561-8780, www.pac.ca.gov"

Benjamin M. Willett, PA-C, CA Lic#56490

_____
Printed Patient Name

_____ _____
Patient Signature Date

Allergy & Asthma Associates of Southern California

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Use this form when you want to transfer records
to our office from a different office.

PLEASE PRINT - THANK YOU!

PREVIOUS DOCTOR: _____

ADDRESS: _____

_____

_____

TELEPHONE/FAX#: _____

☐ All Medical Records (including lab results, visit notes, and procedures)

☐ Date Range:_____ to _____

PLEASE FORWARD A COMPLETE COPY OF MY MEDICAL RECORDS
INCLUDING ALLERGY TEST RESULTS AT MY REQUEST TO
ALLERGY & ASTHMA ASSOCIATES OF SOUTHERN CALIFORNIA
27800 MEDICAL CENTER ROAD #244
MISSION VIEJO, CA 92691

PLEASE PRINT - THANK YOU!

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY# _____

SIGNATURE _____ _____
PATIENT, PARENT OR GUARDIAN DATE

PRINTED NAME _____
PARENT OR GUARDIAN (if different from patient)

Expires 1 year of the date of signature but may be revoked sooner if done in writing

---

FOR OFFICE USE ONLY:
ACTION: PREPARED BY _____ DATE_____

PLEASE CIRCLE ONE: MAILED FAXED TO BE PICKED UP DATE_____

Mission Viejo · 27800 Medical Center Road, Suite 244 · Mission Viejo, CA 92691
Irvine · 15785 Laguna Canyon Rd., Suite 100 · Irvine, CA 92618
Phone: (949) 364-2900 · **Fax**: (949) 365-0117

Allergy and Asthma Associates of So. Cal.

(949) 364-2900

Effective Date: 09/23/2013

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 understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. 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 protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. 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 Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we 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 medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative 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 protected health information. 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 their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

5. Notification and Communication With Family. We may disclose your health information 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 information to a relief organization so that they may coordinate these notification efforts. We may also disclose information 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 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.

6. 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. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. 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 medical information 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.

7. Sale of Health Information. We will not sell your health information 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.

8. Required by Law. As required by law, we will use and disclose your health information, 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 health information 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. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of 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 if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information 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 health information to coroners in connection with their investigations of deaths.

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

15. Public Safety. We may, and are sometimes required by law, to disclose your health information 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.

16. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

17. Specialized Government Functions. We may disclose your health information 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 health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

20. Breach Notification. In the case of a breach of unsecured protected health information, 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.

21. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose 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 health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information 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 restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial 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 health information 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 Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, 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, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee 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 under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information 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 health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

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 Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Michael Leoz, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019

OR
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**.
You will not be penalized in any way for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION
FOR
Allergy and Asthma Associates

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from Allergy and Asthma Associates a copy of the Notice.

_____
Patient's Name (Please Print)

_____
Signature

_____
Relationship To Patient

Date:_____

Allergy & Asthma Associates of Southern California

Leading-edge, personalized care you can trust

Consent for Telemedicine Services with Insurance

As a way to care for our patients we are now offering telemedicine services. This will be a way for you to real-time communicate with the medical provider using an audio and video connection. To participate in this program requires several acknowledgements.

By initialing below, you acknowledge that you will be videoconferencing with one of the available providers of the practice at a scheduled time. _____ (Initials)

By initialing below, you acknowledge that you will only be using ModMed, which will need to be downloaded to either your PC or mobile device and which also uses HIPAA compliant encryption, to connect with the provider. In addition, I understand and give consent for these conversations to be recorded with the intent of them to be transcribed in the medical record. It is at A&A's discretion to delete them once they have been transcribed. _____ (Initials)

By initialing below, you acknowledge that ***if*** your insurance company finds you ineligible for this benefit you will be responsible for a $75 charge to be billed to you after your insurance has processed your claim. _____ (Initials)

By initialing below, you agree to send us an image of your current insurance card prior to the Telehealth Visit being scheduled. _____ (Initials)

By initialing below, I acknowledge that this is not an in-person examination I release Allergy & Asthma Associates of Southern California and its individuals personally from liability as it relates to these services. _____ (Initials)

By signing below, I, the patient or their legal guardian, show that I understand and acknowledge the requirements as described above.

☐ Please check this box if you **DECLINE** the use of telehealth now or in the future.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Patient Name/Legal Guardian (Printed) Patient Name (If Minor)

Rev. 9/28/22

Appointment Cancellation/No Show Policy

Thank you for trusting your medical care to Allergy & Asthma Associates of Southern California. When you schedule an appointment with our practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

Effective September 1, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a $75 fee.

As a courtesy, when time allows we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Allergy & Asthma Associates of Southern California 24 hours a day, 7 days a week at (949) 364-2900.

_____

Patient/Legal Guardian Name

_____ _____

Patient/Legal Guardian Signature Date

PATIENT PARTICIPATION PACKET

This medical office is partnering with our electronic health record (EHR) company to develop an artificial intelligence powered tool, with the goal of making it easier and more efficient for doctors to prepare their chart notes. We are asking for your consent to participate in the development of this tool by allowing us to record the **audio** of your health care visit with your provider. If you participate, the audio of the visit will be recorded through our EHR company's software as described on the next two pages. To help you better understand this program, here are some answers to Frequently Asked Questions.

What do I need to do if I want to participate?
To provide consent, you will sign the next two pages of this packet. The first page is a consent allowing our EHR company (Modernizing Medicine, Inc., known as ModMed) to use the audio recording and its content for technology development. The second page is an authorization specifically related to the use of your health information. Your doctor will also ask you verbally for consent before turning on the audio recorder during any given visit.

What will be recorded?
We will be recording the audio or verbal conversation with your doctors and other health care personnel at this office. We will not be recording any video.

If I agree to participate, will all of my future doctor visits be recorded automatically?
No. You have the option at each visit with our office to tell the provider if you are comfortable with that visit being recorded. Your provider will ask you for your permission before turning on the recorder at any visit. In addition, some providers at our office may decide not to record certain visits.

What will my recordings be used for?
The recordings will be used for developing the artificial intelligence powered tool designed to help physicians more effectively document their visits with patients.

Who will listen to my recordings?
In general, no one will listen to your recordings. The recording content will be used to inform and develop the artificial intelligence technology and computer algorithms designed to help improve clinical documentation. There may be times when a ModMed employee or contractor needs to listen to your recording for troubleshooting or other development purposes.

Will my recordings be kept forever?
No, the recordings will be deleted six months after the visit. ModMed may keep a written transcript of the recording for longer. If so, ModMed will use technology designed to remove content from the transcript that may identify you or your provider.

Can I change my mind after signing the consent?
Yes, you can revoke your consent by emailing mmaiscribe@modmed.com or you can tell your provider not to record a particular visit.

Does participating affect the quality of care I receive?
No, you will receive the same quality of care regardless of whether you participate, and your participation is entirely voluntary.

Are there any benefits to me participating?
There are no tangible benefits to you participating. However, you may enjoy intangible benefits knowing that you helped contribute to improving health care technology and making it easier for doctors to document their visits with patients, which could ultimately help improve patient care.

What if a friend or family member is with me at an appointment?
Any visitors with you at an appointment that is being recorded should sign the first consent form in this packet. Please notify the front desk if your friend or family member has not signed this form. (Visitors do not need to sign the second consent form, which is specifically about the health care information that is discussed.)

RELEASE FOR PROVIDER INTERACTION CONTENT

For the intangible value gained from participation in the improvement of health care technology and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, I (or a third party authorized to act on my behalf) ("**Participant**") hereby grant to Modernizing Medicine, Inc., a Florida for-profit corporation, and its affiliates, subsidiaries, licensees, agents, successors, designees, and assigns (collectively, "**Company**") the right to use Participant's name, likeness, voice, conversation, sounds, and/or material (collectively, my "**Appearance**") as follows:

1. Participant agrees that Company shall have the right to create and capture audio-only works, including recordings of and from Participant's Appearance and interactions with health care providers and/or patients (the "**Content**") by any method of recording without further consent from or any royalty, payment, or other compensation to Participant.
2. Participant acknowledges and agrees that for each health care visit between Participant and a health care provider and/or patient (each visit, a "**Provider Interaction**"), the Content includes: (a) an audio recording of the Provider Interaction, with such audio recording to be retained by Company for a period not to exceed six months, (b) a transcript of such audio recording, with such transcript to be retained by Company for a period not to exceed six months, and (c) a modified transcript of the audio recording that has been processed using third-party technology and/or tools designed to remove content from the transcript that would identify the patient, health care provider, and/or Participant. Company will retain such modified transcript for as long as the Company so chooses.
3. Participant agrees that Company shall forever own all rights, including copyright, in the Content and the results and proceeds of such Content, and shall have the irrevocable right to use, and license others to use, the Content in whole or in part, an unlimited number of times, in all languages, in all media whether now known or hereafter devised, anywhere in the universe in connection with the development and improvement of Company technology that may be used to help improve clinical documentation and physician practice management, including without limitation, distribution of the Content to any and all persons present at a Provider Interaction, anyone employed by or affiliated with Company who listens to the recording of the Provider Interaction after it is recorded or reviews a transcript of the recording, and anyone the Company may hire or contract with to capture, transcribe, edit or de-identify the recording or assist in the development of the Company products. Company shall have the right to edit the Content in any manner or form. Participant hereby waives any right of inspection or approval of Participant's Appearance, including any Content related to Participant's Appearance.
4. Participant hereby releases, discharges, and holds harmless Company from all claims, demands, or causes of action that Participant may have or receive from a third party, including without limitation, claims based upon defamation, invasion of privacy, rights of publicity, commercial disparagement, or any other claims arising from the creation of or use of the Content or Participant's Appearance.
5. Company is not obligated to actually use Participant's Appearance or the Content.
6. This Appearance Release shall be governed by the laws of the State of Florida (excluding its conflicts of law principles), regardless of the place of its physical execution and shall be binding on me and my successors, parents, licensees, legal representatives, heirs, and assigns (as applicable). Participant hereby submits to the jurisdiction of the state and federal courts of Palm Beach County, Florida, to resolve any dispute arising out of or resulting from this Appearance Release. Participant shall not raise, and hereby waives, any defenses based upon improper venue, inconvenience of the forum, lack of personal jurisdiction, or the sufficiency of service of process. Termination of this Appearance Release, for any reason, shall not affect Company's rights in the Content. Company may assign its rights in the Content, in whole or in part, to any individual or entity, without restriction.
7. This Appearance Release represents the entire understanding and supersedes all prior understandings between the parties relating to the subject matter herein.

AGREED AND ACCEPTED

Participant Name: _____

Signature: _____ Date: _____

Authorization for Use and Disclosure of Protected Health Information for Recording

Patient Name: _____ Date: _____

By signing this form, I authorize my physician or other provider ("Provider") to record the audio of my interactions with the Provider using the recording tool provided by Modernizing Medicine, Inc. (the "Company"). I understand that the Company will record and access such recordings for purposes of the development and improvement of Company technology that may be used to help improve clinical documentation and physician practice management.

Information to be Used and Disclosed: All audio information heard or recorded in connection with or during my interaction(s) or visit(s) with my Provider from October 1, 2023 through December 31, 2024 ("Provider Interactions"), including without limitation, conversations, sounds, audiotapes, and/or verbal statements made during the Provider Interactions by anyone present, and my demographic, biographical, and medical information (including any and all clinical documentation) related to such Provider Interactions.

Persons Authorized to Receive Information: (1) Any and all persons present at the Provider Interactions, (2) anyone employed by or affiliated with Company who, for purposes of development and improvement of Company technology, listens to the recording of the Provider Interaction after it is recorded or reviews a transcript of the recording or associated clinical documentation, and (3) anyone the Company may hire or contract with to capture, transcribe, edit, aggregate, or modify the recording or transcript or to assist in development of the product(s).

Purposes: For development and improvement of Company technology that may be used to help improve clinical documentation and physician practice management. I understand and agree that Company will store my information in its audio-recorded format for a maximum period of six (6) months. I further understand and agree that Company will create a transcript of the recording to be retained for a maximum period of six (6) months from the date of the Provider Interaction that was recorded. I understand and agree that no later than six (6) months after the date of the recorded Provider Interaction, the Company will destroy the recording and will use third-party technology and/or tools designed to remove content from the transcript that may identify me and that Company will retain such modified transcript for as long as the Company so chooses.

Right to Revoke: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting an email to Company at mmaiscribe@modmed.com, or (if revoking during the Provider Interaction), by informing my provider. Unless revoked, this authorization will expire on December 31, 2024. After expiration or revocation of this authorization, the Company may continue to use and disclose any modified transcripts created from Provider Interactions that occurred before I revoked consent. The Company may destroy or dispose of recordings and transcripts at any time without notice to me.

Re-disclosure/Voluntary Consent. I understand the information disclosed by this authorization may be subject to re-disclosure by anyone receiving it, and the information disclosed will no longer be protected by federal privacy laws and regulations. This authorization is voluntary. I understand that neither the Company nor my provider may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form.

_____ _____

Signature of Patient or Representative Date

_____

Description of Representative's authority to act on behalf of Patient, if applicable