Illinois Allergy & Asthma Specialists

Dr. Amishi Singal Murthy & Dr. Vivian Chou

COS Building • 2500 Ridge Ave • Suite 211A • Evanston, IL 60201
3000 Halsted Street • Suite 724 • Chicago, IL 60657
Phone: (847) 328-7909 • Fax: (847) 328-7919
www.ilallergyasthma.com

New Patient Registration Form

Date: _____Patient Name: _____ Date of Birth: _____

Preferred Name: _____ SSN: _____ Sex: _____Marital Status: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: Primary: (_____) _____-_____ Secondary: (_____) _____-_____ Tertiary: (_____) _____-_____
Indicate which phone number is preferred: _____
OK to leave message regarding normal test results on voice mail? Please check one: ◯ Yes ◯ No

Email Address: _____
*Please refer to *Enrollment in Online Patient Health Record Access and Email Communication Authorization* for details.

If minor, name of parent/guarantor: _____ Relation: _____

Emergency contact:
Name: _____ Relationship to patient: _____ Phone: (___) _____-_____

Preferred pharmacy: _____ Phone: (___) _____-_____
Address: _____City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone: (___) _____-_____
Address: _____City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: (___) _____-_____
Address: _____City: _____ State: _____ Zip: _____

PRIMARY Insurance:
Insurance Company: _____ Subscriber ID #: _____ Group #: _____

Billing Address (if different from above): _____ City: _____State: _____ Zip: ____

Insured's name: _____ Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____ Employer's phone: (___) _____-_____

Employer's Address: _____City: _____ State: _____ Zip: _____

Co-Pay amount: $_____

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SECONDARY Insurance (if applicable):
Insurance Company: _____ Subscriber ID #: _____ Group #: _____

Billing Address (if different from above): _____ City: _____State: _____ Zip: ____

Insured's name: _____ Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____ Employer's phone: (___) _____-_____

Employer's Address: _____City: _____ State: _____ Zip: _____

Co-Pay amount: $_____

Authorization for Medical Care, Payment and Release of Information

I, the undersigned, hereby authorize the physicians of Illinois Allergy and Asthma Specialists, SC to render medical evaluation and treatment for the named patient. I authorize payment of medical benefits for any services furnished to me or to the patient by Illinois Allergy and Asthma Specialists, SC. I understand that I am financially responsible for any amount not covered by my contract. I authorize Illinois Allergy and Asthma Specialists, SC to release any information acquired in the course of my evaluation or treatment to any provider, other party, or my insurance company or their agent for the purpose of treatment, payment, or practice operations.

Cancellation and Delinquent Account Policy

To best service the schedules of our patients: for office visits canceled less than 24 hours in advance, or failure to keep an appointment, patients may incur a $50 charge. All accounts not paid within 60 days will be forwarded to a collection agency.

Signature: _____ Date: _____

Printed Name: _____ Patient's Name: _____

Credit Card type: ◯ Visa ◯ MasterCard ◯ AMEX (online payment only) ◯ Discover (online payment only)

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

I hereby acknowledge receipt of the medical services, authorize IAAS to bill the above credit card for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in your agreement with the credit card issuer.

I authorize IAAS to process the above credit card as "card on file." I will be notified when my credit card is charged. I understand this authorization will remain in effect until the expiration of the credit card account. Patient also may revoke this form by submitting a written request to the medical practice.

I have read and understand the financial policy of this medical office and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without prior written notice. _____ Initial

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Enrollment in Online Patient Health Record Access and Email Communication Authorization

Illinois Allergy and Asthma Specialists (IAAS) is inviting you to access your patient health record online. By agreeing to the terms below, you will have access to your health record, including certain lab results, online. When you enroll, you will receive an email inviting you to create an online account. You will also receive a PIN from our office, which you will need to sign up. You will not receive unwanted email/spam from IAAS. In addition, you may also choose to communicate via email with your physician. Please see below regarding our policies for email communication.

- Email should be used for NON-EMERGENCY purposes only.
- Your doctor may not be checking email frequently and may take 48-72 hours to respond to your emails. Emails will not be answered over the weekends, holidays, or after business hours. Regular business hours are from 9 am to 5 pm, Monday through Friday.
- For any emergencies, please call 911.
- For any urgent issues, please call the office at 847-328-7909.
- Email communications from your physician may NOT be encrypted, and the security of such emails cannot be guaranteed.
- All email communications and pictures will be filed in your or your child's permanent medical record.
- Please inform this office in writing if you change your email address.

I hereby give consent to my physicians, Dr. Amishi Singal Murthy and Dr. Vivian Chou, and the staff of Illinois Allergy and Asthma Specialists, to communicate with me via email. I understand and agree to the above policies regarding email communication. I also wish to enroll for online access to my patient health record online.

Current email address: _____

Printed name of patient: _____

Signature of patient/parent/guardian: _____ Date: _____

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HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) 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 practice creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

We are required by federal and state law to maintain the privacy of your medical information. Medical information is also called "protected health information" or "PHI." The medical record is the property of this medical practice, but the information in the medical record belongs to you.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health- related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are unavailable, we may leave this information in a message in your voicemail inbox or with the person answering the phone.

Sign In: 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.

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.

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.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may disclose your health information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

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.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclosure PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: We do not engage in fundraising activities. We do not engage in marketing activities and need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

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.

Breach Notification: As required by law, we will notify you if you are affected by a breach of your unsecured PHI.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal and state laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to accommodate to your request, except as required by law. The practice is required to comply with your request for restrictions on the use or disclosure of your PHI to health plans for payment or health care operations purposes when the practice has been paid out of pocket in full and the practice has been notified of the request for restriction in writing, and the disclosure is not required by law.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

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Amendments of Your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at (847) 328-7909. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for marketing purposes, for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations), You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, you can get a revised Notice by stopping by our office to pick up a copy or online at www.ilallergyasthma.com. Changes to the Notice are applicable to the health information we already have.

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Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Illinois Allergy and Asthma Specialists to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
(*Patient's Name*)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available online at www.ilallergyasthma.com

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Communication with Family Members/Parents/Others:

We take patient confidentiality very seriously. In addition to yourself or your child, please specify another person(s) with whom we may discuss your test results/health information, if so desired

◯ I want my test results/healthcare information reported only to me

◯ Dr. Chou and Dr. Murthy have my permission to speak with the following individuals only (Please include name/relationship and telephone number):

1. _____
2. _____
3. _____

Signed: _____ Date: _____

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