SouthCoast ALLERGY

Patient Information

Please Print

Patient's Last Name _____ **First** _____ **Middle Initial** _____

Social Security Number _____ **Date of Birth** _____ **Age** _____ **Sex:** ☐ Male ☐ Female

Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Primary Phone _____ ☐ Home ☐ Work ☐ Cell **Alternate Phone** _____ ☐ Home ☐ Work ☐ Cell

Email Address _____

EMERGENCY CONTACT: _____ **Relationship:** _____ **Phone #:** _____

Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Employment Status (check one) ☐ Full Time ☐ Part Time ☐ Retired ☐ Other **Student** ☐ Full Time ☐ Part Time

Race (check one) ☐ White ☐ African American/Black ☐ Asian ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ Native Hawaiian ☐ Declined to report

Ethnicity (check one) ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to report

Employer _____ **Occupation** _____

Employer Address _____

INSURANCE Primary: _____ **Member ID #:** _____ **Group #:** _____

Insured: Last _____ First _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

SSN _____ Date of Birth _____ Employer _____

Secondary Insurance: _____ **Member ID #:** _____ **Group #:** _____

FOR HIPAA PURPOSES (Privacy Act): I authorize discussion of my (my child's) medical information with:

☐ Patient only (parent or legal guardian, if minor) ☐ the following people (Name/Relationship) _____

_____

How were you referred to this office? ☐ Physician ☐ Friend ☐ Family ☐ Insurance ☐ Internet ☐ Other _____

Referring Physician _____ Should we send notes to this doctor? ☐ Yes ☐ No

Address _____ Phone _____

Primary Care Physician (if different) _____ Should we send notes to this doctor? ☐ Yes ☐ No

Address _____ Phone _____

Preferred Pharmacy _____ Phone _____

Pharmacy Address _____

_____ _____

Patient/Guardian Signature **Date**

SouthCoast Allergy, P.A.

Patient's Name:	Date of Birth:

PREVIOUS ALLERGY EVALUATION AND THERAPY ☐ N/A

Have you ever had allergy skin tests? ☐ Yes ☐ No If yes, date _____ Physician's Name _____

Results of these tests: (If possible, please provide us with a copy) _____

_____

Have you ever received allergy injections? ☐ Yes ☐ No If yes, give dates: _____

HOSPITALIZATIONS (Please list) ☐ N/A

1. _____
2. _____
3. _____

SURGERIES (Circle all that apply) ☐ N/A

Adenoids/Tonsils Removed	Appendectomy	C-Section
Gallbladder (Cholecystectomy)	Colon Resection	Hernia Repair
Deviated Septum	Ear Tubes	Organ Transplant
Hip/Knee Surgery	Hysterectomy	Other _____
Pacemaker	Sinus Surgery	_____
CABG (Heart Bypass)	Thyroid Surgery	_____

FAMILY HISTORY

	Mother	Father	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	Siblings	Children
Age								
Alive Yes / No								
Allergies								
Anaphylaxis								
Angioedema								
Asthma								
Cystic Fibrosis								
Eczema								
Food Allergies								
Heart Disease								
Hives								
Hypertension (High Blood Pressure								
Hyperlipidemia (High Cholesterol)								
Immunodeficiency								
Infection, Recurring								
Venom Allergies								
Other _____								

SOCIAL HISTORY

Social Information	Yes / No	Details
Smoking or other Tobacco Products		
Exercise		
Pets		
Distilled Water		
Alcohol Intake		
Home Heating – A/C		
Travel Outside U.S.		
Occupation Exposure		

Reviewed by: _____ **Date:** _____

SouthCoast Allergy, P.A.

Patient's Name:	Date of Birth:

BP _____ Temp _____ Pulse _____ Respiration _____ Weight _____ Height _____

HISTORY OF YOUR PRESENT ILLNESS

What is the chief problem that brings you to see the doctor? _____

When did your problem start? _____

How many times has your problem occurred? _____

When was the last time you had problems? _____:_____

When you have a problem, how long does it last? _____

Is it worse at any certain time of day, week or year? (Circle all that apply)
AM PM Weekday Weekend Spring Summer Fall Winter Other _____

Is there anything that seems to trigger your problem? (Circle all that apply)
ALLERGY PATIENTS ONLY: Grass Dust Mold Cleaning Solutions Smoke Perfume A/C Heat Other _____

Is there anything that improves your problem? (Circle all that apply)
ALLERGY PATIENTS ONLY: Antihistamines Decongestants Nasal Steroids Nasal Decongestants Oral Steroids Antibiotic Albuterol Inhaled Steroids Other _____
Are there other associated symptoms that occur? _____

CURRENT MEDICATIONS AND SUPPLEMENTS (Include Milligram and number of times per day- Continue on back if needed)

Medication	Strength	Times per day	Taking for what diagnosis

ALLERGIES TO MEDICATIONS ☐ N/A

Medication Name	Reaction (Hives, Throat Swelling, other reactions)

PAST ALLERGY PROBLEMS (Have you ever had the following conditions? ☐ N/A

		Age of Onset	Comments
Animals	Yes No		
Asthma (Wheezing)	Yes No		
Any other Breathing Problems	Yes No		
Sinus Trouble	Yes No		
Hay Fever (Runny, Stuffy, Itchy Nose) Sneezing	Yes No		
Hives or Swelling	Yes No		
Eczema or Other Rashes	Yes No		
Frequent Infections	Yes No		
Food Reactions	Yes No		
Drug Reactions	Yes No		
Insect Reactions	Yes No		
Latex	Yes No		
Metals	Yes No		

Reviewed by: _____ Date: _____

SouthCoast Allergy, P.A.

Patient's Name:	Date of Birth:

CARDIAC HISTORY

Congestive Heart Failure	Yes No	Coronary Artery Disease	Yes No
Mitral Valve Prolapse	Yes No	Damaged Heart Valves	Yes No
Artificial Heart Valves	Yes No	Heart Attack	Yes No
Rheumatic Fever	Yes No	Low Blood Pressure	Yes No
Cardiovascular Disease	Yes No	Congenital Heart Defects	Yes No
Angina	Yes No	Pacemaker	Yes No
Arteriosclerosis	Yes No		

WOMEN ONLY ☐ N/A

Are you Pregnant?	Yes No	Number of Weeks	
Taking Birth Control Pills	Yes No	Taking Hormone Replacement	Yes No
Nursing	Yes No		

BIRTH HISTORY - PEDIATIC PATIENTS ONLY (Younger than 12 yrs old) ☐ N/A

Birth Weight: APGAR Score: <6 7 8 9 10	
Delivery : Complicated Uncomplicated	**Route:** Vaginal C-Section Induced
Complications in neonatal period: Yes No	**Development:** N/A Normal Delayed
Child was born: ☐ Premature ☐ Full Term	**Breast Fed:** ☐ Yes ☐ No
Feeding Difficulties: ☐ Yes ☐ No	**Late on Immunizations:** ☐ Yes ☐ No
Siblings: ☐ Yes ☐ No (If yes, how many?)	**Attends:** ☐ School ☐ Daycare
	Name of School/Daycare

Reviewed by: _____ **Date:** _____

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SOUTHCOAST ALLERGY, P.A.

REVIEW OF BODY SYSTEMS

Date: _____

Does the patient have any of the following symptoms TODAY?
Check YES or NO for each. PLEASE DO NOT LEAVE ANY BLANK SPACES

General	Yes	No
Always tired	( )	( )
Chills	( )	( )
Difficulty gaining weight	( )	( )
Fever	( )	( )
Loss of appetite	( )	( )
Night sweats	( )	( )
Overweight	( )	( )
Trouble sleeping	( )	( )
Weight gain	( )	( )
Weight loss	( )	( )
Other		

Head	Yes	No
Dizziness	( )	( )
Headache	( )	( )
Recurrent sinus infection	( )	( )
Sinus pain	( )	( )
Sinus problem	( )	( )
Other		

Ears	Yes	No
Clogged ears	( )	( )
Earaches	( )	( )
Ear drainage	( )	( )
Hearing problems	( )	( )
Recurrent infections	( )	( )
Ringing or popping ears	( )	( )
Tinnitus	( )	( )
Vertigo	( )	( )
Other		

Eyes	Yes	No
Blurred vision	( )	( )
Burning	( )	( )
Cataracts	( )	( )
Contact lenses	( )	( )
Darkness under eyes	( )	( )
Double vision	( )	( )
Drainage	( )	( )
Dry eyes	( )	( )
Frequent blinking	( )	( )
Itchy eyes	( )	( )
Red eyes	( )	( )
Swelling around the eyes	( )	( )
Vision changes	( )	( )
Watery eyes	( )	( )
Other		

Mental Health	Yes	No
No Problem	( )	( )
Depression	( )	( )
Anxiety	( )	( )
Hyperactivity Problem	( )	( )
Behavior Problems	( )	( )

Nose	Yes	No
Change in sense of smell	( )	( )
Itchy nose	( )	( )
Nasal congestion	( )	( )
Nasal discharge	( )	( )
Nasal polyps	( )	( )
Nose bleeding	( )	( )
Runny nose	( )	( )
Sneezing	( )	( )
Other		

Mouth/Throat	Yes	No
Difficulty swallowing	( )	( )
Drip in back of throat	( )	( )
Dry mouth	( )	( )
Excessive snoring	( )	( )
Frequent mouth sores	( )	( )
Hoarseness/Laryngitis	( )	( )
Itchy throat	( )	( )
Mouth breathing	( )	( )
Recurrent infections	( )	( )
Snoring	( )	( )
Sore throat	( )	( )
Swollen lips	( )	( )
Swollen tongue	( )	( )
Throat tightness	( )	( )
Other		

Cardiovascular	Yes	No
Chest pain	( )	( )
High blood pressure	( )	( )
Increased heart rate	( )	( )
Murmurs	( )	( )
Palpitations	( )	( )
Other		

Respiratory	Yes	No
Chest tightness	( )	( )
Cough at night	( )	( )
Coughing up blood	( )	( )
Documented history of low oxygen	( )	( )
Dry cough	( )	( )
Frequent bronchitis/ Chest colds	( )	( )
Frequent coughing	( )	( )
Recurrent pneumonia	( )	( )
Shortness of breath	( )	( )
SOB during day	( )	( )
SOB during night	( )	( )
SOB on exertion	( )	( )
Wet cough	( )	( )
Wheezing	( )	( )
Other		

Gastrointestinal	Yes	No
Abdominal pain	( )	( )
Bloating/excessive gas	( )	( )
Blood in the stool	( )	( )
Burping	( )	( )
Constipation	( )	( )
Diarrhea	( )	( )
Food intolerance	( )	( )
Gas	( )	( )
Heartburn/indigestion	( )	( )
Nausea/vomiting	( )	( )
Regurgitation	( )	( )
Trouble swallowing	( )	( )
Other		

Genitourinary	Yes	No
Increased urinary frequency	( )	( )
Painful urination	( )	( )
Urine retention	( )	( )
Other		

Endocrine	Yes	No
Diabetes	( )	( )
Excessive thirst	( )	( )
Tired/Sluggish	( )	( )
Too hot/cold	( )	( )
Other		

Musculoskeletal	Yes	No
Arthritis	( )	( )
Back pain	( )	( )
Fractures	( )	( )
Joint pain	( )	( )
Joint redness	( )	( )
Joint stiffness	( )	( )
Joint swelling	( )	( )
Muscle pain	( )	( )
Muscle stiffness	( )	( )
Muscle weakness	( )	( )
Neck pain	( )	( )
Other		

Skin	Yes	No
Boils	( )	( )
Contact reactions	( )	( )
Eczema	( )	( )
Hair loss	( )	( )
Hives	( )	( )
Persistent itch	( )	( )
Recurrent abscess	( )	( )
Recurrent infections	( )	( )
Skin rash	( )	( )
Swelling	( )	( )
Other		

Allergy/Immunology	Yes	No
Drug allergy	( )	( )
Food allergy	( )	( )
Hay Fever	( )	( )
Insect allergy	( )	( )
Check Local Hives Generalized		
Recurrent Infection	( )	( )
Check Bacterial Fungal Viral		
Other		

Neurological	Yes	No
Concentration problems	( )	( )
Dizzy spells	( )	( )
Excessive daytime sleeping	( )	( )
Fainting spells	( )	( )
Insomnia	( )	( )
Nonrestorative sleep (not rested after)	( )	( )
Numbness	( )	( )
Restless sleep (frequent change in position)	( )	( )
Seizures	( )	( )
Stops breathing (apnea)	( )	( )
Tingling	( )	( )
Tremors	( )	( )
Other		

Hemo/Lymph	Yes	No
Anemia	( )	( )
Bleeding disorders	( )	( )
Blood clotting problem	( )	( )
Easy bruising	( )	( )
Swollen glands	( )	( )
Other		

Tobacco Use	Yes	No
Cigarette		
Check 1. Daily 2. Socially 3. Rarely 4. Never		
No. of cigarettes/day		
No. of packs/day		
Cigars		
Check 1. Daily 2. Socially 3. Rarely 4. Never		
No. of cigars/day		
No. of cigars/week		
Other		
Tobacco Exposure	Yes	No

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☐ All systems negative except noted.

DAM version 8

Patient Name: _____ Patient Signature: _____

Physician/PA/NP: _____ Reviewed by: _____

SOUTHCOAST ALLERGY, P.A.

Financial and Insurance Policy

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. To assist us in this mission, we request that you read and sign the following financial policy prior to services being rendered.

Insurance - We participate with most insurance programs, **but it is your responsibility as the policyholder to contact the insurance company to determine what your covered benefits are.** You should also know the labs and diagnostic centers that participate with your plan. It is impossible for us to keep track of all the individual requirements of the many various plans. Although we verify your coverage, **verification of benefits is NOT a guarantee of payment from your insurance company.** Your insurance company doesn't guarantee your benefits until the claim has been **filed.** As a courtesy to you, we will file all medical claims with your primary, secondary and tertiary insurance. Please provide us with your current insurance card(s) and any authorization information you may have. Notify us immediately if there are changes in this information. If you have two or more insurances, we expect you to know which carrier is primary and secondary. It is the responsibility of the patient or responsible party to see that all charges are paid in full. Your insurance company will send you an explanation of benefits that explains what they have paid to our office. If you do not agree with their payment, **please contact the insurance company directly.**

Referrals – If you are a new patient whose plan requires a referral for treatment, the authorization from your PCP must be requested by you. If you belong to an HMO or have Tricare Prime, we must have a current referral from your primary care physician **before** you can be seen. It is a courtesy to you that we check to see if your authorization is current. However, it is your responsibility to contact your insurance to update your referral as needed.

Amount of Charges - Total charges for services rendered and any insurance benefits which are calculated at the time of checkout are ***estimated*** based on information available at the time. We may amend such charges based on services rendered and insurance payments actually received. The undersigned specifically agrees to pay any such additional or amended charges upon receipt of the bill or notice. You agree to pay for procedures or services which are not covered under your insurance policy, you agree to pay SouthCoast Allergy, P.A. for those charges ***in advance*** of services or procedures being performed. Patient over payments on individual charge items will be applied to other unpaid charges.

Collections:

a. Patient accounts will be turned over to a collection agency after 90 days (3 billing statements) if the balance is not paid in full or payment arrangements have not been made with the Billing Department. There will be a $25.00 service fee added to the balance of any accounts being referred to a collection agency. Questions regarding your bill should be directed to our billing office at 850-279-6520.

b. Once an account is turned over to collections, the patient will not be seen in our clinic until the account balance is paid in full.

c. There will be a $25.00 service charge for all returned checks.

Financial Policy: I, the patient, understand I will receive a statement for any balance that may be due to the physician as a result of the following: Co-insurance or copayments, annual deductible amounts, non-covered service, out of network charges, terminated coverage, exhausted benefits, no insurance coverage, and failure to respond to insurance company correspondence or inquiries. I understand and agree that the balance on my statement will be paid in full to the physician within 90 days.

Insurance Assignment: I hereby authorize my insurance benefits to be paid directly to SouthCoast Allergy, P.A. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

I have read, understood, and agree to abide by the policies set forth by SouthCoast Allergy, P.A.

_____ _____

Print Name of Patient Signature of Patient/Guardian

_____

Date

South Coast Allergy
4592 East Hwy 20 Ste3 Niceville, FL 32578
southcoastallergy.com
Main: 850-279-6520

Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.

4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.

6. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.

8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.

9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.

10. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and

that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Name as it Appears on Card/ACH Account Email Address

Billing Address City State Zip Code

Phone Number

AUTHORIZED SIGNATURE _____ DATE _____

Name as it Appears on Card/ACH Account Email Address

Billing Address City State Zip Code

Phone Number

AUTHORIZED SIGNATURE _____ DATE _____

SOUTHCOAST ALLERGY, P.A.

Office Policies

Testing: Our providers frequently order diagnostic testing prior to return visits and the results will be discussed at your next scheduled appointment. Our receptionist schedules follow up testing and appointments when you check out. It is our policy that test results not be released to the patient prior to reviewing them with a provider.

Prescriptions: If you have prescriptions that need to be refilled, you will need to contact your pharmacy and have them fax a refill request to our office at 850-897-1259. Please do not call our office for refills for medications not prescribed by the providers in our office. All refill requests will be addressed within 24 - 72 hours. Please be sure to check your medications **before** you run out. There will be a $20.00 charge for any last minute emergency refills that have to be called in.

If your insurance company denies a medication you've been on or a prescription that is not a covered drug, you will need to contact the insurance company for a list of alternative drugs covered by your insurance provider. Our office does not call insurance companies to obtain a list of covered medications. It is the patient's responsibility to do this.

Messages/Telephone Calls: All messages and telephone calls will be returned within 48 hours. Due to a number of factors, we may not always be able to get back to you the same day you call. Your call/message will be returned within 48 hours.

Missed Appointments/Rescheduled Same Day Appointments: Please understand that when you reserve an appointment with our office, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. To assist all our patients with appropriate access to our providers, we will charge a fee of $50.00 for any office visit appointment cancelled with less than 24 hour notice. This fee is not covered by your insurance company. Patients that arrive more than 15 minutes late for their appointment will be rescheduled. We ask that you arrive for your appointment at least 10 minutes early. That will ensure the provider will have the appropriate time to spend with you on your visit.

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

Spending Account Receipts: Receipts for Spending Accounts can be requested from our Billing Department, but please be aware the turn- around time to receive a copy is 5 business days.

I have read, understood, and agree to abide by the policies set forth by SouthCoast Allergy, P.A.

_____ _____

PRINT Name of Patient Signature of Patient/Guardian

_____

Date

SouthCoast Allergy, P.A.

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.

Each time you visit a physician, hospital, or other healthcare providers, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, plan for future care or treatment, and billing related information. Your record represents Protected Health Information.

We are committed to treating and using Protected Health Information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This notice applies to all Protected Health Information, as described by federal regulations, which is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAYS WE USE AND DISCLOSE HEALTH INFORMATION

For Treatment: We may use your health information to provide you with medical treatment or services. We may disclose medical information about you to other health professionals who contribute to your care (such as doctors, nurses, technicians, or other personnel who are involved in taking care you you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine if your plan will cover it, unless you exercise your right to restrict. **

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service for making copies of your health records, e-Prescribing service, a person who provides data transmission services, computer software vendor, and subcontractors that create, receive, maintain or transmit your medical information on behalf of the contracted Business Associate as required by Omnibus HIPAA Rule compliance. When services such as these are contracted, we may disclose your health information to our business associates so they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information as required by HIPAA regulations.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

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.

Communication with Family or Friend: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

For Research, Marketing, Fundraising: We may disclose information to researchers when an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. Our office does not sell our protected health information. Any activity for research, marketing or fundraising requires your written authorization.

We may also use and disclose medical information to/for the following:

* To remind you that you have an appointment
* To assess your satisfaction with our services
* Food and Drug Administration
* Organ and Tissue Donation Organizations
* Health Oversight Agencies
* Funeral Directors, Coroners, Medical Directors
* To notify or assist in notifying a disaster relief entity so your family can be notified about your health status
* Public Health Authorities
* Workers Compensation Agents
* Legal Authorities
* Military Command Authorities
* National Security & Intelligence
* Protective Services for the President of the U.S.
* for law enforcement purposes as required by law or in response to a subpoena

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. 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 the denial be reviewed. We are allowed to charge you for these copies. If capabilities exist, you may request access to your medical records in electronic format.

Amend: If you feel medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment; and if this occurs, you will be notified of the reason for denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction of limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authorities, Food & Drug Administration, work-related injury, and OSHA compliance.

** Restricted Disclosure: You have the right to restrict disclosure of your personal protected health information to your health plan/insurance company if that information pertains solely to healthcare for which you (or a person on your behalf) paid for the testing or treatment in full, out of pocket. You must continue to pay out of pocket for subsequent care related to restricted disclosure.

Genetic Information: Your genetic information is treated as Protected Health Information. It cannot be used to discriminate against you for the provision of health insurance or for underwriting purposes.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

Breach: You will be notified within sixty days if a reportable breach of your Protected Health Information occurs.

A paper copy of this notice: You may ask us to give you a copy of this notice.

If you have any questions about this notice, or believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office, 850-279-6520. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

We reserve the right to change this notice and to make the new provisions effective for all Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include the effective date.

You may revoke your permission to use or disclose medical information about you, in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided to you.

By signing this document, I acknowledge that I have read the Notice of Privacy Practices for SouthCoast Allergy, P.A.

_____	_____	_____
PRINT Name of Patient	Signature of Patient/Guardian	Date

OFFICE USE ONLY:

Date Acknowledge received _____ by _____

OR Reason Acknowledgement was not obtained _____

Updated 1-1-15

Updated 1-1-15

SOUTHCOAST ALLERGY, P.A.

Medical Information Release Authorization

TO OUR PATIENTS:

This form gives us your permission to send copies of your medical records to your referring physician and to the insurance companies processing your claims for payment. It will be used for no other purpose. Any other outside agency requesting your records must submit a specific authorization, signed by you, with each and every request

I authorize SouthCoast Allergy, P.A. to release to insurance carriers, the Social Security Administration and Health Care Financing Administration (or its intermediaries or carrier) any information needed to process any insurance and/or Medicare claim related to medical services provided by SouthCoast Allergy, P.A. and its affiliates. I understand that in order to provide appropriate care to patients, SouthCoast Allergy, P.A. works closely with Laboratories for testing. I authorize SouthCoast Allergy, P.A. to relay insurance information in an effort to facilitate cooperation between the two entities.

I hereby assign to the physicians all payments for hospitals, medical, surgical services rendered to myself or my dependents.

I understand that I am responsible for any amount not paid by insurance.

I understand and authorize SouthCoast Allergy, P.A., its employees and all other persons caring for me at SouthCoast Allergy, P.A. from any liability connected with the use of these records or the information in them by anyone outside of SouthCoast Allergy, P.A.

I have read, or had read to me, all of the above and understand all parts of the authorization.

_____ _____

PRINT Name of Patient Signature of Patient/Guardian

_____ _____

Date of Birth Social Security Number

_____

Date