



# PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor				
Patient's Social Security Number		California Driver's License No.		
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number		Work Telephone Number		
Occupation		Employer's Name		
Employer's Address	City	State	Zip	
Spouse Name		Employer		
Primary Physician's Name		Referring Physician's Name		
How did you hear about us?				
<b>NOTIFY IN CASE OF EMERGENCY</b>				
Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
Nearest Relative (not living with your)				
Home Telephone		Work Telephone		
<b>FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES [Check if same as above] <input type="checkbox"/></b>				
Name		Telephone		
Address	City	State	Zip	
Insurance Company		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.		
Insurance ID No.:		Group #:		
Secondary Insurance		Claim Address		



Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#
Were You Injured on the Job?	YES NO	Have you Informed Your Employer? YES NO
Date of Original Injury:		
Worker's Compensation Carrier Name	Address	

**Please Read Our Financial Policy Statement and Agreement**



# HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: June 4<sup>th</sup> 2010

**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.**

If you have any questions about this notice, please contact Manjul S Dixit, MD.

## WHO WILL FOLLOW THIS NOTICE

- This notice describes our hospital's practices and that of:
- Any health care professional authorized to enter information into your hospital chart.
- All departments and units of the hospital.
- Any member of a volunteer group we allow to help you while you are in the hospital.
- All employees, staff and other hospital personnel.

[List any other hospitals in your system, subsidiaries or other entities that will follow this privacy notice].




All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or hospital operations purposes described in this notice.

## OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

-  make sure that medical information that identifies you is kept private;
-  give you this notice of our legal duties and privacy practices with respect to medical information about you; and
-  follow the terms of the notice that is currently in effect.

## **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

### **For Treatment**

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as family members, clergy or others we use to provide services that are part of your care.

### ***For Payment***

We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to and payment collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

### ***For Health Care Operations***



We may use and disclose medical information about you for hospital operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

#### ***For Appointment Reminders***

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

#### **For Treatment Alternatives**

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

#### **For Health-Related Benefits and Services**

We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

#### **For Fund Raising Activities**

We may use medical information about you to contact you in an effort to raise money for the hospital and its operations. We may disclose medical information to a foundation related to the hospital so that the foundation may contact you in raising money for the hospital. We only will release contact information, such as your name, address and phone number and the dates you received treatment or services at the hospital. If you do not want the hospital to contact you for fund raising efforts, you must notify Manjul S Dixit, MD in writing.

#### **For Hospital Directory**

We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be



given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

#### *To Individuals Involved in Your Care or Payment for Your Care*

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

### **For Research**

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects,

however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the hospital. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the hospital.

### **As Required By Law**

We will disclose medical information about you when required to do so by federal, state or local law.

#### *To Avert a Serious Threat to Health or Safety*

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will only be to someone able to help prevent the threat.

#### **SPECIAL SITUATIONS**

### **Organ and Tissue Donation**



If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

## **Military and Veterans**








If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. [A hospital that is a component of the Department of Defense or Transportation Department should also include the following: "If you are a member of the Armed Forces, we may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the Department of Veterans Affairs to determine if you are eligible for certain benefits."] [A hospital that is a component of the Department of Veterans Affairs should also include the following: "We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits."]

## **Workers' Compensation**

We may release medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

## **Public Health Risks**

We may disclose medical information about you for public health activities. These activities generally include the following:

-  to prevent or control disease, injury or disability;
-  to report births and deaths;
-  to report child abuse or neglect;
-  to report reactions to medications or problems with products;
-  to notify people of recalls of products they may be using;
-  to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
-  to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.



## **Health Oversight Activities**







We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

## **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

## **Law Enforcement**

We may release medical information if asked to do so by a law enforcement official:

-  in response to a court order, subpoena, warrant, summons or similar process;
-  to identify or locate a suspect, fugitive, material witness, or missing person;
-  about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
-  about a death we believe may be the result of criminal conduct;
-  about criminal conduct at the hospital; and
-  in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

## **Coroners, Medical Examiners and Funeral Directors**

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

## **National Security and Intelligence Activities**

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.



## **Protective Services for the President and Others**

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. [Hospitals which are components of the Department of State should also include the following: "Security Clearances. We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials in the Department of State who need access to that information for these purposes."]

## **Inmates**

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release will be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; and/or (3) for the safety and security of the correctional institution.

## **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the following rights regarding medical information we maintain about you:

### **Right to Inspect and Copy**

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.





To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Manjul S Dixit, MD. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

### ***Right to Amend***

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital.

To request an amendment, your request must be made in writing and submitted to Manjul S Dixit, MD. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

-  was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
-  is not part of the medical information kept by or for the hospital;
-  is not part of the information which you will be permitted to inspect and copy; or
-  is accurate and complete.

## **Right to an Accounting of Disclosures**

You have the right to request an "Accounting of Disclosures." This is a list of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to Manjul S Dixit, MD. Your request must state a time period which may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

### ***Right to Request Restrictions***

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Manjul S Dixit, MD. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

## **Right to 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, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Manjul S Dixit, MD. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

#### ***Right to a Paper Copy of This Notice***

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, [www.athertonallergist.com](http://www.athertonallergist.com). To obtain a paper copy of this notice, Manjul S Dixit, MD.

#### ***CHANGES TO THIS NOTICE***

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the hospital. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

#### ***COMPLAINTS***

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact Acute Allergy Asthma and Immunology of Atherton 3301 El Camino Real, Ste 101 Atherton, CA 94027 (650) 556-9577. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, 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. You 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 that we provided to you.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_





# NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

**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!**


Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

[Provider Note: You must include at least one example of use or disclosure for treatment, payment, and healthcare operations, but you may provide more than one example. The examples below are suggestions and should be edited/or replaced to apply to the circumstances of your health care practice.]

## **Examples of uses of your health information for treatment purposes are:**

-  A nurse obtains treatment information about you and records it in a health record.
-  During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

## **Example of use of your health information for payment purposes:**

-  We submit requests for payment to your health insurance company. The health insurance company or business associate helping us obtain payment requests information from us regarding the medical care given. Acute Allergy Asthma and Immunology of Atherton will provide information to them about you and the care given.

## **Example of Use of Your Information for Health Care Operations:**

We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. Acute Allergy Asthma and Immunology of Atherton will share information about you with such business associates as necessary to obtain these services.

### *Your Health Information Rights*

The health and billing records we maintain are the physical property of the doctor's office. You have the following rights with respect to your Protected Health Information







1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but Acute Allergy Asthma and Immunology of Atherton will comply with any request granted;
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
3. Right to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; appeal a denial of access to your protected health information except in certain circumstances;
4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request; and,

If you want to exercise any of the above rights, please contact Manjul S Dixit, MD, in person or in writing, during normal hours. S[he] will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

### ***Our Responsibilities***

The office is required to:



-  Maintain the privacy of your health information as required by law;
-  Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
-  Abide by the terms of this Notice;
-  Notify you if we cannot accommodate a requested restriction or request;
-  Accommodate your reasonable requests regarding methods to communicate health information with you; and
-  Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices, and to enact new provisions regarding the protected health information we maintain. If our information practices change, CMS will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

### ***To Request Information or File a Complaint***

If you have questions, want additional information, or want to report a problem regarding the handling of your information, you may contact [Manjul S Dixit, MD \(650\) 556-9577](#).

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to [Manjul S Dixit, MD](#). You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is [The U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Washington, D.C. 20201 Toll Free: 1-877-696-6775](#).

-  We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
-  We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.



*Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule*

**Patient Contact**

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may contact you as part of a fund raising effort.

**Notification—Opportunity to Agree or Object**

Unless you object we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family—Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

We may use and disclose your protected health information to assist in disaster relief efforts.

**Opportunity to Agree or Object Not Required**

***PUBLIC HEALTH ACTIVITIES***

Controlling Disease—As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Child Abuse & Neglect –We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.

Food and Drug Administration (FDA)—We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

[Provider Note: Health care providers working for an Industry performing medical surveillance or evaluating whether the individual has a work-related injury or illness may disclose PHI pertaining to the work-related injury or illness to the employer if the employer needs the findings in order to comply with OSHA regulations.]

[A statement to this effect must be included in the privacy postings of such physicians.]



#### ***VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE***

We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.

#### ***OVERSIGHT AGENCIES***

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations; inspections; licensures or disciplinary actions; and for similar reasons related to the administration of healthcare.

#### ***JUDICIAL/ADMINISTRATIVE PROCEEDINGS***

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.

#### ***LAW ENFORCEMENT***

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.

#### ***CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS***

We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

#### ***ORGAN PROCUREMENT ORGANIZATIONS***

Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.

#### ***RESEARCH***



We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

#### **THREAT TO HEALTH AND SAFETY**

To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

#### **FOR SPECIALIZED GOVERNMENTAL FUNCTIONS**

We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.


#### **CORRECTIONAL INSTITUTIONS**

If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.


#### **WORKERS COMPENSATION**

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

#### **Other Uses and Disclosures**

 Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

#### **Website**

 If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: \_\_\_\_\_ *(Must be date when first in effect)*

[Provider Note: You should consult your state law to avoid potential conflicts or contradictions with the uses and disclosures defined in this document.]

Patient Signature: \_\_\_\_\_

## FINANCIAL POLICY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**BASIC POLICY** Pay for service is due in full at the time service is provided in our office.

**FOR PATIENTS WITH INSURANCE** We bill most insurance carriers for you if proper plan information is provided to us. We will also bill most secondary insurance companies for you. Copayments and outstanding patient responsible balances are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

**MEDICARE PATIENTS** We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments are due and payable at the time service is provided.

**NONCOVERED SERVICES** Any care covered by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

**PERSONAL INJURY CASES** This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

**WORKER'S COMPENSATION** If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.

**YEARLY HEALTH CHECKS** Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.

**MISSED APPOINTMENTS:** In fairness to other patients and the doctor, we require at least 24 hour notice to cancel and/or change appointments. You will be charged \$100.00 for failure to comply and/or missed appointments. You may be discharged from the practice for 3 missed appointments and/or failure to notify us within 24 hours of cancelation.

- There will be a \$25.00 charge for each returned check.
- There will be a 1.5%/month assessed for late payments.

Please check on: I have paid my insurance deductible for the calendar year \_\_\_\_\_  Yes  No  Don't know

**MEDICARE PATIENTS: SIGNATURE ON FILE** I request payment of authorized Medicare benefits be made either to me or on my behalf to Manjul S Dixit, MD for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.



Patient's Name (Please Print):	<b>PROVIDER</b>
Patient's Signature: _____ Patient's Medicare No.: _____ Date: _____	

**ASSIGNMENT OF INSURANCE BENEFITS** Patients with insurances please read and sign below.  
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Acute Allergy Asthma and Immunology of Atherton. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I state all information provided is accurate and I am financially responsible for services and claims not covered due to incorrect information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have read, understood, and agreed to the above financial policy for payment of professional fees.  
**The patient is ultimately responsible for all professional fees.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## FEE EXPLANATION

Dear Patient:

**Your fee for service includes your visit with the doctor based on the time and complexity of your condition and any treatment provided. In addition, proper attention to your case requires that the doctor spends more time working for you outside your direct visit with him or her, such time may include:**

- Creation of a permanent medical record.
- Review of all laboratory blood test results (e.g., a biochemical survey and CBC contain 42 separate test to interpret and file in your chart).
- Review of prior and current x-ray or scan reports and personal review with the radiologist of abnormal studies.
- Preparation and mailing of consultation reports and follow-up visits letters and laboratory/scan results to referring physicians and any subsequent consulting.
- Follow-up phone call or letter regarding laboratory test results of patients and/or copies of test results when indicated or requested.
- Phone consultation with referring or consulting physicians and other health care providers about your case.
- Other phone calls to and from you and your family members for various reasons.
- Referral letters to any further specialists recommended by the doctor.
- Patient educational materials and medication samples when available.
- Any research done by the doctor about your case. The doctor used medical libraries and computerized medical search services.
- Staff assistance regarding your visit.
- Arranging and coordinating other tests and consultations.
- Calls to and from pharmacies.
- Insurance application forms: health insurance, disability insurance, life insurance.
- Insurance reports: health claims, disability claims to insurance and state, Medicare disability.
- Discussions (sometimes acrimonious) with hospitalization utilization review, insurance companies, or Medicare for ongoing hospitalization.
- Review and management of hospital records.
- Letters of necessity to obtain medical instruments or prescriptions.
- Letters of necessity for medical services to insurance companies.
- Arrangements for hospitalization with hospital admissions, house staff physicians and consulting physicians, and test/treating facilities.
- Communication daily during admission with nurses, house staff, and attending physicians.
- Tumor registry and other required reports.
- Home health care and nursing facility orders.
- Other reports and forms: jury duty, school, job, sick leave, back to work, communicable disease, etc.

In addition, the doctor participates extensively in continuing medical education, clinical research, teaching, and medical writing to keep up-to-date on the latest medical advances.

At our office, we feel a strong commitment to keep costs to our patients down. Even so, the cost of salaries, rent, taxes, insurance, billing, postage, photocopying, medical supplies, office supplies, medical journals and textbooks, and other materials keeps increasing. We charge only what we feel is necessary in order to maintain the highest standard of care. We look forward to a lasting and healthy relationship with you.

Sincerely,

Patient Signature:

Manjul S Dixit, MD



- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law. Date: \_\_\_\_\_ I authorize \_\_\_\_\_  to pick up my protected health information,  have access to my PHI. Picture ID required. Signature: \_\_\_\_\_
- This authorization shall become effective immediately and shall remain in effect for six months from date of signature.
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that AAAIA has already disclosed the information.
- I understand that I have a right to receive a copy of this authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by other than the patient, indicate relationship: \_\_\_\_\_