Allergy & Asthma
DIAGNOSTIC TREATMENT CENTER

Office of Dr. Ronald Saff and Christine Stabley, PA-C
2300 Centerville Road | Tallahassee, FL 32308
Phone: (850) 386-6680 | Fax: (850) 386-7902

| **Patient Information** | | | |
|---|---|---|---|
| Today's Date: | | | |
| Patient Name (first, middle, last): | | | |
| Primary Care Physician: | | Referring Physician: | |
| Sex: Male □ Female □ | Smoker: Yes □ No □ | Date of Birth: | SSN (Last 4): |
| Cell Ph: | Home Ph: | Work Ph: | |
| Address: | | | |
| City/State/Zip: | | Email: | |
| **Emergency Contact Information** | | | |
| Name: | Relationship: | Phone Number: | |
| Address: | | | □ Same As Self |
| City/State/Zip: | | Email: | |
| **If the patient is <u>your</u> child…** | | | |
| Your Name (First, Middle, Last): | | | Your SSN (Last 4): |
| Your Address: | | | □ Same As Self |
| City/State/Zip: | | Email: | |
| Cell Ph: | Home Ph: | Work Ph: | |
| **If you are a <u>college student</u>…** | | | |
| Billing Contact Name: | | Relationship: | |
| Permanent/Billing Address: | | | □ Same As Self |
| City/State/Zip: | | Email: | |
| Cell Ph: | Home Ph: | Work Ph: | |
| **Primary Insurance Information** | | | |
| Policy Holder's Name: | Relationship: | | DOB: |
| Policy Holder's Address: | | | □ Same As Self |
| City/State/Zip: | | Email: | |
| Insurance Name: | Employer: | Date Eligible: | |
| Policy/ID Number: | | Group Number: | |

Note: We do not file for your secondary insurance benefits; it is your responsibility. [HIPAA? Y / N ]

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Rev. 2/18/15

| Referrals | | |
|---|---|---|
| I understand that it is my responsibility to provide Allergy & Asthma Diagnostic Treatment Center with the proper referrals required by my insurance company. Any treatment I receive that is not authorized or becomes denied by my insurance company is my responsibility to pay. | | |
| **Signature:** | | **Date:** |

| Payment for Services | | |
|---|---|---|
| I understand that Allergy & Asthma Diagnostic Treatment Center will file my claim to my primary insurance as a courtesy to me, but I am responsible to see that this bill is paid, either by insurance or another party. I understand that my copayment and any previous balances are due when I check out. I understand that it is my responsibility to file my own secondary insurance. I also understand that outside laboratory services may be performed and that my insurance company or I will be billed directly by the outside facility. | | |
| **Signature:** | | **Date:** |

| Release of Protected Health Information | | |
|---|---|---|
| I hereby authorize Allergy & Asthma Diagnostic Treatment Center and Dr. Ronald H. Saff to release protected medical or other information needed about me for this and any future medical claims to my insurance company. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits to Allergy & Asthma Diagnostic Treatment Center and Dr. Ronald H. Saff, who has accepted my assignment of benefits. | | |
| **Signature:** | | **Date:** |

**If you have not already, please present your photo identification and all relevant insurance cards our receptionist for photocopying.**

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Effective September 1, 2013

# HIPAA Omnibus Notice of Privacy Practices and Acknowledgement

**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 of Privacy Practices describes how our office and our business associates (and their subcontractors) may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

*Treatment*: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you've been referred, DME vendors, surgery centers, hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters, nurse case managers, etcetera to ensure that the healthcare provider has the necessary information to diagnose or treat you.

*Payment*: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etcetera, may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

*Healthcare Operations*: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment and inform you about treatment alternatives or other health related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law, public health issues, communicable diseased, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, workers' compensation, inmates, and other required used and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

## USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We will not use or disclose any of your protected health information that contains genetic information that will be use for underwriting purposes. You may revoke authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

(Continued on back)

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**YOUR RIGHTS**

*You have the right to inspect and copy your protected health information (fees may apply)* – pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administration action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or another person or information that was obtained under a premise of confidentiality.

*You have the right to request a restriction of your protected health information* – this means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction request and to whom you want the restriction o apply. Your physician is not required to agree to your requested restriction except if you request the physician not disclose protected health information to your health plan with the respect to healthcare for which you have paid in full out of pocket.

*You have the right to request to receive confidential communications* - You have the right to request confidential communication form use by alternative means or at an alternative location. You have the right to receive a paper copy of this notice upon request, even if you have agreed to this notice alternatively (i.e. electronically).

*You have the right to request an amendment to your protected health information* – If we deny your request for amendment, you have the right to file a statement of disagreement with use and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

*You have the right to receive an accounting of certain disclosures* – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; require by law that occurred prior to September 1, 2013 or six years prior to the date of the request.

*You have the right to obtain a paper copy of this notice from us* even if you have agreed to receive this notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We also will make available copies of our new notice if you wish to obtain one.

**COMPLAINTS**

You may complain to use or to the Secretary of Health and Human Services if you believe that we have violated your privacy rights. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

| **Compliance Officer** | **Phone Number** | **Email Address** |
|---|---|---|
| Bonnie Bussell | (850) 386-6680 | bonniebussell@aadtc.us |

**ACKNOWLEDGEMENT OF THESE POLICIES** **EMPLOYEE INITIALS _____**

Patient Name (Printed): _____

Signature of Patient, Parent or Guardian: _____ Date: _____

**We strive to stay on the cutting edge of medicine by offering our patients clinical studies. Participation in clinical studies entitles you to study-related treatment and medication. Additionally, there is financial compensation for your time. If you would like information for you, a family member, or a friend, please let us know. Please leave a phone number, email address and a good time to call you.**

Home: _____ Cell: _____ Email: _____

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Ph. (850) 386-6680 | Fax (850) 386-7902

Hives, Swelling, Rashes, Insect Allergy & Medication Reactions Packet

Dear Patient,

We strive to stay on the cutting edge of medicine by offering our patients clinical studies. Participation in a clinical research study entitles you to study-related treatment and medication at no cost to you. Additionally, there is financial compensation for your time and travel. If you are interested, please let a staff member know.

All of our patients are treated with the highest level of expertise and your information is kept strictly confidential.

Ronald H. Saff, M.D., CCRI

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General Information

1. The government requires all physicians to protect the privacy of patients' medical records. You can read this policy titled "HIPAA Omnibus Notice of Privacy Practices and Acknowledgement" which is incorporated as part of your new patient packet. A copy is also available immediately on your request.
2. Patients are expected to keep their appointments. Failure to cancel an appointment 48 hours prior may result in a missed appointment fee of $40.
3. Patients requesting refills are required to make periodic appointments to ensure good medical care.

Please sign to acknowledge that you have read and understand the above statements.

_____ _____

Signature Date

*Allergy & Asthma Diagnostic Treatment Center*
2300 Centerville Road | Tallahassee, FL 32308
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Date: _____

| **Patient Name:** |
|---|
| Date of Birth: |
| Single □ Married □ Divorced □ |
| Patient Address: |
| |
| |
| **Patient Contact Information** |
| Home Phone: |
| Cell Phone: |
| Work Phone: |
| Email: |
| |
| **Primary Care and Insurance Information** |
| Name of Family Physician: |
| Name of Medical Insurance Company: |
| |
| **If the doctor could help you with one thing that is bothering you the most, what would it be?** |

| ***If you are a minor:*** |
|---|
| **Parent's Contact Information** |
| Parent's Name: |
| Parent's Address: |
| |
| |
| Parent's Home Phone: |
| Parent's Cell Phone: |
| Parent's Work Phone: |
| Parent's Email: |

| **How did you hear about us?** |
|---|
| Referred by doctor: Yes □ No □ |
| Referred by friend: Yes □ No □ |
| Internet: Yes □ No □ |
| Insurance Listing: Yes □ No □ |
| Name of Referring Doctor: |
| Name of Friend: |
| Name of Website: |
| |
| |

| **Optional**: If we may discuss your care with another individual, please indicate who: | | |
|---|---|---|
| | Name | Relationship |

| If we are treating another member of your family, please give their name and their relationship to you | |
|---|---|
| Name: | Relationship: |



Initials _____

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Patient Name _____

Patient DOB _____

## Mark Yes, No, or N/A

### Patient, please fill out this side:

What were you doing when you first broke out in hives or swelling?

Did you have a cold or other type of illness (circle): Yes No

When did the first episode occur?

How many times has it occurred subsequently?

Have you started any new prescription drugs during the time of the hives or swelling (circle one)? Yes No

If you have, please name them:

What seems to trigger the hives or swelling?

**Is there a relationship of the hives or swelling to:**

| Variable | Yes | No |
|---|---|---|
| Sunlight? | □ | □ |
| Vibrations? | □ | □ |
| Pressure? | □ | □ |
| Hot or cold weather? | □ | □ |
| Hot or cold water? | □ | □ |
| Exercise? | □ | □ |
| Food? | □ | □ |
| Laundry Detergent? | □ | □ |

If seen by another physician, what did the other doctor say?

Were blood tests ordered (circle one)? Yes No

What medications were prescribed?

Did the prescriptions work (circle one)? Yes No

Did they make you sleepy (circle one)? Yes No

| Have you experienced any swelling of the… | Yes | No |
|---|---|---|
| Throat? | □ | □ |
| Tongue? | □ | □ |
| Eczema? | □ | □ |
| Any other swelling? | □ | □ |
| Parental history of swelling? | □ | □ |

Please continue onto the next page.

### Physician Notes:

CC: _____

(4 or more)

☐Location: _____

☐Quality: _____

☐Severity: _____

☐Duration: _____

☐Timing: _____

☐Context: _____

☐Mod. Factors: _____

☐Assoc. Signs & Symptoms: _____

☐ Reviewed above page

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Patient DOB _____

## Mark Yes, No, or N/A

### Do you have any other type of Allergy Problems?

| Problem | Yes | No |
|---|---|---|
| Sinus congestion? | □ | □ |
| Nasal Blockage? | □ | □ |
| Runny Nose? | □ | □ |
| Itchy, watery eyes? | □ | □ |
| Sneezing? | □ | □ |
| Post-nasal drip? | □ | □ |
| Coughing? | □ | □ |
| Wheezing? | □ | □ |
| Shortness of breath? | □ | □ |
| Severe fire ant or bee sting reactions? | □ | □ |

### Current Environment

Please check all that apply.

| | |
|---|---|
| □ Townhouse | □ Wall to Wall Carpet |
| □ House | □ Area Rugs in Bedroom |
| □ Apartment | □ Fireplace |
| □ Mobile Home | □ Air Cleaner |
| □ In City | □ Cigarette Smoke |
| □ In Subdivision | □ Forced Air Heat |
| □ In Country | □ Air Conditioning, Central |
| □ On Farm | □ Air Conditioning, Window |
| □ Cats | □ Humidifier |
| □ Dogs | □ Dehumidifier |
| □ Birds | □ Damp Basement |
| □ Other Pets | □ Mold Growth |
| □ Feather Pillow | □ Lots of Houseplants |
| □ Down Pillow | □ Allergies Improve on Trips |
| □ Down Comforter | □ Air Freshener |

### All Current Medications

Please include over the counter medications and supplements.

| Medication | Amount of Dose | Times Per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### Physician Notes:

☐ Reviewed above page

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Patient Name _____

Patient DOB _____

## Mark Yes, No, or N/A

### Past Medical History

Any chronic health conditions? These include hypertension, diabetes, anemia, stomach ulcers, etc.

| Name of Condition |
|---|
| |
| |
| |
| |
| |
| |

**Which doctors take care of you for these conditions?**

| | |
|---|---|
| Dr. | Dr. |
| Dr. | Dr. |

**Have you had any surgeries?**

| Type of Surgery | Age or Year of Surgery |
|---|---|
| | |
| | |
| | |
| | |

**Have you had any injuries?**

| Type of Injury | Age or Year of Injury |
|---|---|
| | |
| | |
| | |
| | |

**Are you allergic to latex? Yes □ No □**

### Drug Allergies

| Medication | | Symptom |
|---|---|---|
| | *caused* | |
| | *caused* | |
| | *caused* | |
| | *caused* | |
| | *caused* | |
| | *caused* | |

### Immunization Adverse Reactions

| Immunization | | Symptom |
|---|---|---|
| | *caused* | |

**Please let us know when or if these tests were performed.**

| Test | Month/Year | Where |
|---|---|---|
| Sinus X-Ray | | |
| Chest X-Ray | | |
| Sinus CT Scan | | |
| Blood Count | | |

### Physician Notes:

☐ Reviewed above page

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**Mark Yes, No, or N/A**

## Family History

| Family Member | Allergies | Asthma |
|---|---|---|
| Does your **father** have... | □ | □ |
| Does your **mother** have… | □ | □ |
| Does your **brother** have… | □ | □ |
| Does your **sister** have… | □ | □ |

| Question | Yes | No |
|---|---|---|
| Is your father alive? | □ | □ |
| Does your father have any health problems? | □ | □ |
| Please list them: | | |
| If deceased, what did he die from? | | |
| Is your mother alive? | □ | □ |
| Does your mother have any health problems? | □ | □ |
| Please list them: | | |
| If deceased, what did she die from? | | |

## Social History

| Question | Yes | No |
|---|---|---|
| Do you smoke? | □ | □ |
| If so, how much? | | |
| When did you start? | | |
| Have you smoked in the past? | □ | □ |
| When did you quit? | | |
| Are there any other smokers in the house? | □ | □ |
| Is there use of any recreational drugs? | □ | □ |
| Do you drink any alcohol? | □ | □ |
| If so, what kinds of drinks? | | |
| How much and how often? | | |
| What is your occupation? | | |
| What are your hobbies? | | |

## Please check the boxes of applicable conditions:

| | |
|---|---|
| □ Fever | □ Fatigue |
| □ Weight Loss | □ Arthritis |
| □ Blood in Stools | □ Muscle Problems |
| □ Joint Swelling or Pain | □ Stomach Upset |

□ Neurologic Problems (such as seizures)
□ Blood Count Problems (anemia, etc.)
□ Eye Problems, explain:
□ Thyroid/other hormone problems (like hot flashes)
□ Infections (explain)
□ Heart Problems or High Blood Pressure
□ Skin Problems Besides Eczema
□ Urinary or Bladder Problems
□ Psychiatric Problems, explain:
□Headache, or other neurological problems:

End of patient information

## Physician Notes:

Adopted?_____

Packs per day:_____

Address at least 5 relevant issues:_____

☐ Reviewed above page

_____ Initials

Name: _____ Date: _____

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**Page for Doctor's Use Only:**

Dx (2+):_____

_____

_____

_____

_____

_____

_____

_____

Complexity:

□Data Reviewed (medical records, bloodwork, x-rays):_____

_____

□Ordered tests (x-rays, bloodwork): _____

_____

□PFTs/Skin Test:_____

_____

_____

_____

_____

Plan:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Risk Level Assessment:

□Low:-Chronic Diagnosis Controlled
-Acute uncomplicated

□Moderate: -New diagnosis with uncertain prognosis
-1 or more chronic illnesses with exacerbation or side effects of treatment
-Status asthmaticus/allergic reaction
-Multiple prescriptions

□ High: -Severe exacerbation
-Need for hospitalization