DESERT CENTER FOR ALLERGY AND CHEST DISEASES

Patient last name:	First name:	Middle:

Parent/Guardian Name: (if applicable)

Birth Date:	Social Security No:	Sex:	Marital status (Circle one)
/ /		○ Male ○ Female	Single / Married / Divorced / Widowed Spouse Name:

Race: (circle one) African American Native American Asian Caucasian Pacific Islander Declined

Ethnicity: (circle one) Hispanic/Latino Not Hispanic/Latino Declined **Language: (Circle one)** English Spanish Other_____

Street address:

City:	State:	Zip Code:

Home Phone:	Cell Number:	Work Number:
○ Preferred number (check one)	○ Preferred number (check one)	○ Preferred number (check one)

May we leave a message at: (Circle preference) Home Cell Work All

Email address:

Primary Insurance:	Policy ID #/Subscriber ID #:	Group #:

Policy holder:	Policy holder date of birth:	Relationship to Pt:

Secondary Insurance:	Policy ID # / Subscriber ID #:

Primary Care Doctor:	Phone:	Fax:
Referring Doctor:	**Phone:**	**Fax:**
Notify in case of emergency:	**Phone:**	**Relationship to Pt:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Desert Center for Allergy and Chest Diseases or my insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

DESERT CENTER FOR ALLERGY AND CHEST DISEASES

STEPHEN N. FINBERG, D.O. | JOHN T. NICEWICZ, M.D. | JAMES A. DAVIS, D.O.
LEAH FINBERG, PA-C | THERESA PINDER, PA-C | ADAM SCHWARTZ, PA-C
UDAY K. REDDY, M. | RICHARD ROBBINS, M.D | MARIANNE CURRAN, PA-C

Pulmonary Medicine, Allergy/Immunology, Sleep Disorders
Pulmonary Rehabilitation, Pulmonary Function Laboratory

Financial Policy

In order to provide you with proper handling of your charges in our office we ask that you carefully read and then sign the following statement of our financial policy prior to treatment. **It is your responsibility to be aware of your benefits**. Exclusion, pre-existing conditions, referrals and terminated benefits may nullify insurance coverage and transfer full responsibility to you, the responsible party. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. All insurance information, including prior authorizations, referrals, and claim forms when necessary, must be provided **at the time of service.** We do not change or re-code our claims once they have been billed to your insurance. This falls into unethical medical office practices.

As a courtesy to our patients, we do file secondary insurance IF the information is provided. If payment is not received within 45 days of billing however, we do ask you to take care of the remaining balance.

This office also has a policy to ask that you update your information to ensure current information at least once a year. It is your responsibility to keep us advised if changes are more frequent.

This office bills **only for services performed by our office.** Any outside services will be billed by the facility performing the procedure and/or laboratory work. You will need to contact them on any billing questions you may have

Please **read and sign** the following:

1. I understand that co-pays are due prior to being seen (unless prior arrangements have been made.)
2. If my insurance requires referrals or authorizations prior to treatment, I take full responsibility to obtain it prior to my visit, or I agree to pay all claims denied to the lack of a paper referral.
3. I understand that it is my responsibility to notify the office of any changes to my personal information such as name, address, insurance carrier and/or telephone numbers to properly file my claims.
4. In addition I understand I will be requested, at least, annually to complete new updates to keep my information current. Failure to properly verify this information will stop my insurance from being billed and I will be responsible for payment in full at the time of service.
5. I agree to pay all finance charges, collection cost of 33 and 1/3%, attorney fees, and any other costs that may arise in order to enforce collection of any outstanding debt in which all other efforts have been exhausted.
6. **I understand that that there will be a $25.00 charge if I NO SHOW for an appointment with 24 hours notice and charged $50.00 for no show for procedure appointments. (See fee notice)**
7. I understand that any charges incurred, may be applied to my insurance deductible.
8. I understand and acknowledge **ALL OF THE ABOVE** by signing below.
9. I understand that I will be charged $25 for medical record to be picked up. Mailing records will be extra.

_____ _____

Printed name of Patient Signature of Patient/Date

Please feel free to speak to our billing department if you have any questions. Thank you for your cooperation.

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FEE NOTIFICATION

At Desert Center, we strive to meet and exceed the expectations of all of our patients and we are dedicated to providing you the best care and service possible.

Time is specifically reserved for you on our schedule when you make your appointment. When sufficient notice is not given to cancel or reschedule your appointment, it does not give our office enough time to schedule another patient who could come to the office during your assigned time…this results in other patients not getting the care they need, when they need it.

Since there are many patients waiting for appointments with our physicians, and due to an increase in patients not showing up for their appointments without giving our office advance notice, we have found it necessary to implement a NO-SHOW policy.

A NO-SHOW is when a patient fails to keep a scheduled appointment or without providing 24 hour's cancellation notice. A No-Show will generate a fee of $25.00 and with 3 or more no shows it may require you to seek medical care with another group. If your appointment is an in-office procedure, such as a Rhinoscopy, Rapid Desensitization, Stress test, PCN testing, Patch testing or CPFT our fee in the event that you fail to show for your procedure is $50.00

We understand that there may be issues beyond your control and we want to be understanding of special circumstances.

I have read and fully understand the Patient NO-SHOW policy.

_____ _____

Patient Signature (Parent or Guardian for Minor) **Date**

6970 E. CHAUNCEY LANE #100 PHOENIX, AZ 85054
PHONE 602-788-7211 FAX 602-788-1890

DESERT CENTER FOR
ALLERGY AND CHEST DISEASES

NOTICE OF PRIVACY PRACTICES

To our patients,

This notice will describe how your health information may be used and disclosed, and how you may obtain access of your medical records. This notice referred to as Health Insurance Protection Accountability Act (HIPAA) of 1996.
Our office reserves the right to change this Notice in the future.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are however, permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. We realize that these laws are complicated, but we will attempt to give you an overview of this act. ***You may obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.***

Use and disclosure of your health information:

- During the course of your treatment, if the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialists and obtain his/her input.
- If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' compensation.
- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer.
- We may disclose your health information to funeral directors, medical examiners, or coroners, consistent with applicable law to allow them to carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.
- As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people to recalls; to notify a person who may have been exposed to disease or who is at risk for contracting or spreading a disease or condition.
- We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.
- Our office has the right to obtain medical records from other healthcare facilities/providers for continuity of care.
- If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and the health and safety of other individuals.

- To avert a serious threat to health or safety, we may disclose your 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.
- We may use and disclose your health information 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.
- If we maintain a website that provides information about our office, this Notice will be on the website.
- We may disclose your health information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information has approved their research.

Your health information rights

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- Request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. However, your physician is not required to agree to a restriction that you may have requested. In the event the physician believes it is in the patient's best interest to permit use and disclosure of the protected health information, the protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- Request that you be allowed to inspect and obtain a copy of your medical record and billing record. *You may be required to sign an authorization to obtain this information.*
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request. (We are not required to make such amendments);
- 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.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you have questions, would like additional information, want to report a problem regarding the handling of your information or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact Lisa Stubblefield, Privacy officer. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

Original Effective Date: January 23, 2012

Acknowledgment of Receipt of privacy Notice
Desert center for Allergy and Chest Diseases

Original to be maintained in Patient's permanent medical record.

I acknowledge that I have been offered a copy of the office's Notice of Privacy Practices.

WHO MAY RECEIVE INFORMATION REGARDING YOUR HEALTH INFORMATION? (CHECK ALL THAT APPLY)

____ Spouse Full Name: _____
____Children Full Name (s) _____
____Physician Full Name (s) _____
____Other Full Name (s) _____

The HIPPAA Privacy Rules are available in the provider's office. By my signature, I authorize the above list of persons to receive my Protected Health Information per HIPPA requirements. I may revoke this at anytime by giving written notification to this provider.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name Relationship