Trinity Allergy, Asthma and Immunology Care, P.C.

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200
285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

NEW PATIENT HISTORY FORM

Please answer all questions. Print and bring this form with you at the time of your appointment. Do not mail.

Name _____ Date of Birth _____ Home Phone _____

Age _____ Sex _____ Referring Doctor/ Person _____Insurance:_____

Primary Care Physician _____ Pharmacy _____

1. **Please tell us why you want to consult us. Please write down.**

_____
_____
_____
_____

2. **Did you undergo previous allergy evaluation and allergy injections in the past? ☐ Yes No ☐**

Where	When	Outcome

3. **<u>Only</u> list medications that you have tried for treating allergies or asthma.**

Medications that helped your allergy/asthma	Medications that did not help your allergy/asthma

4. **List of <u>all medications</u> [prescription and over-the-counter] that you are currently taking from all providers.**

Medication	Dose	Times daily	Start date	Any side effects?

5. Do you have symptoms referable to the <u>eyes</u>? Check all that apply. ☐ I have none

☐Bright light bothers your eyes	☐ Get crusty secretions in the eyes	☐ Had eye surgery
☐ Eyes feel dry	☐ Rash on the eyelids	☐ Wearing glasses
☐ Eyes are itching	☐ Swelling of eyelids	☐ Wearing contact lenses
☐ Eyes are red	☐ Have glaucoma	☐ Using eyedrops
☐ Eyes are watering frequently	☐ Have cataracts	☐ Regularly following up with eye Dr.

6. Do you have any symptoms referable to the <u>nostrils/ Sinuses</u>? Check all that apply. ☐ I have none

☐ Itching of the nostrils	☐ Dozing off during daytime	☐ Using CPAP/BiPAP
☐ Frequent sneezing	☐ Reduced sense of smell	☐ Sinus infections 1-3 times per year
☐ Clear runny nose	☐ Frequent nosebleeds	☐ Sinus infections 4-6 times per year
☐ Discolored nasal mucus	☐ Blood stained nasal secretions	☐ Sinus infections more than 6 times per year
☐ Postnasal drip	☐ History of nasal polyps	☐ CT scan of the sinuses within the last 2 years
☐ Nasal congestion	☐ History of deviated nasal septum	☐ CT scan normal
☐ Nasal stuffiness	☐ History of cauterization of the nose	☐ CT scan abnormal
☐ Mouth breathing	☐ History of sinus surgery	☐ ENT doctor follow-up within the last 2 years
☐ Loud snoring	☐ History of polyp surgery	☐ ENT evaluation was normal
☐ Restless sleep	☐ History of surgery for deviated nasal septum	☐ ENT evaluation was abnormal
☐ Feeling fatigued	☐ History of trauma to the face	☐ ENT Dr. recommended allergy evaluation
☐ Feeling irritable	☐ History of hole in the nasal septum	☐ ENT Dr. recommended surgery
☐ Having poor concentration	☐ Have sleep apnea	

7. Do you have any symptoms referable to the <u>throat</u>? Check all that apply. ☐ I have none

☐ Have bad breath	☐ Frequent sore throats	☐ Had tonsils removed
☐ Constant postnasal drip	☐ Frequent strep throats	☐ Had adenoids removed
☐ Clear throat frequently	☐ Frequent tightening of throat	☐ Had surgery for sleep apnea
☐ Frequent hoarseness of voice	☐ Frequent choking	☐ Frequent cold sores in the mouth
☐ Roof of the mouth itches	☐ Throat feels dry on waking up	☐ Frequent canker sores in the mouth

8. Do you have any symptoms referable to the <u>ears</u>? Check all that apply. ☐ I have none

☐ Inside of the ears itch	☐ Ear infections 4-6 times per year	☐ History of ear tubes placement
☐ Ears plugged up frequently	☐ Ear infections greater than 6 times per year	☐ History of ear surgery
☐ Ears pop frequently	☐ Reduced hearing	☐ Have/had speech impairment
☐ Frequent earaches	☐ Frequent dizziness	☐ Have received speech therapy
☐ Ear infections 1-3 times per year	☐ Ringing/buzzing in the ears	☐ Wear hearing aids

9. Check all that apply if you have headaches. ☐ I have none

☐ Headache onset less than one year	☐ **Headaches predominantly affect one side**	☐ **Wakes up with headaches during night**
☐ Headache onset 1-5 years	☐ Headaches predominantly affect both sides	☐ **Family history of migraine present**
☐ Headache onset greater than 5 years	☐ **Nausea with headaches**	☐ **Had eye examination within the last one year**
☐ **Headaches getting worse**	☐ Vomiting with headaches	☐ CT/MRI of the head done
☐ Headaches about the same	☐ Bright light bothers headaches	☐ CT/MRI of the head Normal/ abnormal
☐ Headaches getting better	☐ Loud noise bothers headaches	☐ Take Aspirin/ Tylenol/ NSAID/Pain Medication
☐ **Headaches severity _____/10**	☐ Get visual aura before headaches	☐ Seen by a neurologist within the last 2 years

10. Do you have any of the following <u>chest</u> symptoms? Check all that apply. ☐ I have none

☐ **Cough**	☐ Cough productive of blood	☐ **Last chest x-ray was in the last one year**
☐ Wheezing	☐ **History of tuberculosis**	☐ Chest x-ray normal/abnormal
☐ Tightness of chest	☐ History of Valley fever	☐ Last chest CT scan within the last 2 years
☐ Shortness of breath	☐ History of pneumonia	☐ CT scan of chest normal/abnormal
☐ Nighttime cough	☐ History of pneumonia	☐ **Current smoker**
☐ **Cough following exertion**	☐ History of croup	☐ Ex-smoker
☐ Cough following laughing and talking	☐ History of RSV positive bronchiolitis	☐ Exposed to secondhand cigarette smoke
☐ Cold air makes me cough	☐ History of foreign body aspiration	☐ **Current on influenza vaccine for the year**
☐ Cough more during spring and fall	☐ History of frequent diarrhea	☐ Current on pneumonia vaccine within the last 5 years
☐ Cough more after eating food	☐ **History of emphysema/COPD**	
☐ **Cough productive of white mucus**	☐ History of asthma	
☐ Cough productive of discolored mucus	☐ **Followed by a pulmonary physician**	

11. Do you have any of the following <u>acid reflux</u> symptoms? Check all that apply. ☐ I have none

☐ **Frequent heartburn**	☐ History of Vomiting fresh blood	☐ Taking acid reducing pills
☐ Frequent burping/belching	☐ History of passing black tarry stools	☐ **Upper GI Endoscopy within the last 5 years**
☐ Bringing up food in the mouth after eating	☐ Frequent upper abdominal pain	☐ History of H. pylori infection in the past
☐ Painful swallowing	☐ **Taking NSAIDs frequently**	
☐ Food getting struck while eating	☐ Taking antacids frequently	

12. Do you have any of the following <u>skin</u> symptoms? Check all that apply. ☐ I have none

☐ **Rash**	☐ Rash affecting upper back	☐ Rash worse after menstruation
☐ Itching	☐ Rash affecting lower back	☐ Rash worse after alcohol
☐ Hives/Welts	☐ Rash affecting thighs	☐ Rash worse after dry fruits
☐ Swelling of the eyes, lips, tongue, throat, hands, feet or genitals	☐ Rash affecting legs	☐ **Rash is accompanied by cough**
☐ Eczema	☐ Rash affecting feet	☐ Rash is accompanied by wheezing
☐ Contact dermatitis	☐ **Rash is red**	☐ Rash is accompanied by difficulty breathing

☐ Dryness of skin	☐ Rash is flat	☐ Rash is accompanied by tightness of throat
☐ Skin peeling	☐ Rashes raised	☐ Rash is accompanied by swelling
☐ Skin blisters/blebs	☐ Rash is blistering	☐ Rash is accompanied by stomach cramps
☐ **Rash affecting scalp**	☐ Rash appears pussy and scabbed	☐ Rash is accompanied by diarrhea
☐ Rash affecting the fore head	☐ Rash is discrete	☐ Rash is accompanied by fatigue
☐ Rash affecting cheeks	☐ Rash is diffuse	☐ Rash is accompanied by fever
☐ Rash affecting ears/behind ears	☐ **Rash is made worse by scratching**	☐ Rashes accompanied by weight loss
☐ Rash affecting around mouth	☐ Rash is made worse by sunlight	☐ Rashes accompanied by joint symptoms
☐ Rash affecting eyelids	☐ Rash is made worse by tight clothes	☐ **Family history of hives present**
☐ Rash affecting neck	☐ Rash is made worse by heat and sweating	☐ Family history of swelling present
☐ Rash affecting chest	☐ Rash is made worse by hot showers	☐ Family history of hypothyroidism
☐ Rash affecting the abdomen	☐ Rash is worse in cold weather	☐ Personal history of hypothyroidism
☐ Rash affecting genitals	☐ Rash is worse in the summer	☐ Personal history of hyperthyroidism/Graves' disease
☐ Rash affecting the buttocks	☐ Rash is worse at night	☐ Personal history of goiter
☐ Rash affecting arms	☐ **Rash is made worse by mechanical pressure to skin**	☐ Personal history of lupus/RA
☐ Rash affecting elbows	☐ Swelling is made worse by minor trauma	☐ Personal history of liver disease
☐ Rash affecting forearms	☐ Swelling is made worse by surgery	☐ Personal history of kidney disease
☐ Rash affecting hands	☐ Swelling is made worse by dental work	☐ Personal history of diabetes mellitus
☐ **History of skin warts**	☐ **Started new prescription medication for the rash appeared**	☐ **Name of the soap used**
☐ History of scabies	☐ Taking aspirin	☐ Name of the shampoo used
☐ History of ringworm	☐ Taking NSAIDs	☐ Name of the lotions used
☐ History of skin yeast infection	☐ Taking fiber pills	☐ Name of the sunscreen used
☐ History of frequent cold sores in the mouth	☐ Taking laxatives	☐ Name of the detergent used
☐ History of HIV	☐ Taking herbs	☐ Using Clorox/bleach in the laundry
☐ History of sexually transmitted diseases	☐ Taking hormone pills/injections	☐ Using Bounce/Downy in the dryer
☐ History of hepatitis C	☐ Taking birth control pills	☐ **Evaluation by a dermatologist within the last one year**
☐ History of hepatitis B	☐ Taking suppositories	☐ Had biopsy of skin
☐ **Allergic to poison ivy**	☐ Taking vitamins	☐ Received steroid injection
☐ Allergic to nickel	☐ Taking supplements	☐ Received steroid pills
☐ Allergic to cosmetics	☐ Have dental implant	☐ Last date of steroid injection/pills
☐ Allergic to Neosporin	☐ Have surgical implant	☐ Dermatologist recommended allergy evaluation
☐ Allergic to latex	☐ Any changes in cosmetics before the onset of rash	☐ Dermatologist recommended patch testing
☐ Allergic to new clothes	☐ Any changes in skin and body care products before the onset of rash	
☐ Allergy to wool	☐ **Using topical steroid creams**	
☐ Allergic to leather	☐ Using topical Benadryl cream	
☐ Allergic to deodorants/perfumes	☐ Using topical anti-itch medication	
☐ Allergic to hair dye	☐ Using topical Neosporin	
☐ Allergic to nail polish	☐ Using emollients	
☐ Allergic to eye makeup	☐ Using sunscreens	

13. Which of the following triggers affect your allergy symptoms? Check all that apply. ☐ I have no known triggers

☐ Grasses	☐ High winds
☐ Weeds	☐ Looking at Sun
☐ Trees	☐ Heat
☐ Cat	☐ Cold
☐ Dog	☐ Cigarette smoke/wood smoke
☐ Dust	☐ Perfumes/colognes/hair sprays
☐ Dust mite	☐ Cleaning chemicals
☐ Mold/mildew	☐ Soaps and detergents
☐ Food-name	☐ Cigarette smoke/wood smoke

14. Which of the following do you have in your house? Check all that apply.

☐ Carpet	☐ Birds- how many	☐ Fake houseplants
☐ Tile	☐ Horses- how many	☐ Live houseplants
☐ Wood floor	☐ Smokers living in the house	☐ Stuffed animals in the bedroom
☐ Cats-how many	☐ Central air-conditioning	☐ Stuffed animals on the bed
☐ Dogs- how many	☐ Window air-conditioning	☐ Feather pillows/comforters
☐ Rabbits- how many	☐ Swamp cooler	☐ Grass outside
☐ Rats/ Mice- how many	☐ Recent water leaks in the house	☐ Trees outside
☐ Guniea Pigs/Hamsters-how many	☐ Presence of mold/mildew- Where?	☐ Green areas nearby

15. Do you have any <u>allergy to foods</u>? Answer the following please. ☐ I have none

Name of food you suspect allergy to	Nature of reaction	When

☐ Carry EpiPen	☐ Wear medic alert bracelet
☐ Member of food allergy anaphylaxis network	☐ Have food allergy action plan
☐ Food allergy evaluation by blood test done	☐ Food allergy evaluation by skin test done

16. Do you have any <u>allergy to medications</u>? Answer the following please. ☐ I have none

Name of the medication	Nature of reaction	When

17. Do you have any allergy to <u>bees, wasps, yellow jackets, hornets or fireants</u>? Answer the following. ☐ I have none

Type of insect sting (Bee, wasp, hornet etc.)	Nature of reaction	When

18. Are you allergic to <u>latex</u> (gloves, balloons, condoms, catheters, pacifiers, nipples etc.)? Answer the following. ☐ I have none

Type of material (gloves etc.)	Nature of reaction	When

19. Please tell us about your <u>social history</u>.

☐ **Student**	☐ Drinks alcohol frequently	☐ Not started menstruation yet
☐ Retired	☐ Used street drugs	☐ Attained menopause
☐ Homemaker	☐ Using Street drugs	☐ Had hysterectomy
☐ Unemployed	☐ **Have HIV**	
☐ Disabled	☐ Have/had sexually transmitted disease	**For children**
☐ **Current smoker**	☐ Sexually active	☐ Attends school
☐ Ex-smoker	☐ Using barrier protection	☐ Attends daycare
☐ Years smoked	☐ **Using birth control pill**	☐ Attends baby sitter
☐ Number of cigarettes/ day	☐ Using some other method of contraception	
☐ Year quit smoking	☐ Not pregnant	
☐ Do not drink alcohol	☐ Pregnant	
☐ Drinks alcohol socially	☐ Date of last menstrual period	

20. Please tell us about your <u>family medical history</u>. Check all that apply.

	Father	Mother	Sibling	Grandparents	Children	Aunts	Uncles	Cousins
Hay fever	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐	☐	☐
Swelling/ Angioedema	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐	☐	☐
Acid Reflux	☐	☐	☐	☐	☐	☐	☐	☐

Father	Mother	Sibling	Grandparents	Children	Aunts	Uncles	Cousins	Cousins
Allergy to bees/ wasps	☐	☐	☐	☐	☐	☐	☐	☐
Allergy to latex	☐	☐	☐	☐	☐	☐	☐	☐
Immunodeficiency	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Diseases	☐	☐	☐	☐	☐	☐	☐	☐
Leukemia/ Lymphoma	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐

21. <u>If you are a child under 18 years of age</u>, please tell us about your <u>birth history</u>.

☐ Born greater than 37 weeks gestation	☐ Delivery by C-section	☐ Was in NICU greater than 3 days
☐ Born less than 37 weeks gestation	☐ Required resuscitation at birth	☐ Breast fed
☐ Birth weight	☐ Was on a ventilator	☐ Bottle fed
☐ Normal Delivery	☐ Was in NICU less than 3 days	

22. Please tell us about <u>your immunization status.</u>

Children under 18 years	Adults
☐ Current on all recommended childhood immunizations	☐ Current on influenza vaccine for this season
☐ Not current on all recommended childhood immunizations	☐ Current on pneumococcal vaccine
☐ Current on influenza vaccine for this season	☐ Current on tetanus toxoid vaccine
	☐ Current on shingles vaccine

23. Please tell us if you suffer from any of the following <u>medical conditions.</u>

Medical Condition	Details
☐ Heart problem	
☐ High blood pressure	
☐ High cholesterol/triglyceride	
☐ Diabetes mellitus	
☐ Liver disease	
☐ Kidney disease	
☐ Thyroid problem	
☐ Stomach/intestinal problem	
☐ Female problem	
☐ Prostate problem	
☐ Cancer	
☐ Glaucoma	

Medical Condition	Details
☐ Cataracts	
☐ Osteoporosis/osteopenia	
☐ Arthritis	
☐ Autoimmune diseases	
☐ Blood diseases	
☐ Immunodeficiency	
☐ Sexually transmitted disease/ HIV	
☐ Other medical conditions	

24. Please list hospitalizations, E.R. visits and surgeries

E.R. Visits in the last 5 years	Hospitalizations in the last 10 years	Surgeries during your life

25. Anything Else You May Want Us to Know:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name of the patient **Patient/parent/Legal Guardian's signature** **Date**

Trinity Allergy, Asthma and Immunology Care, P.C.
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285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

REQUEST FOR RECORDS RELEASE TO US

Physician's Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Dear Doctor: _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: _____

Birthdate: _____ Social Security Number: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of the following medical records in your file. Thank you for expediting this request. Please send these records to our office address show above.

1. Office visit notes _____ ☐
2. Hospital records _____ ☐
3. Radiology reports _____ ☐
4. Laboratory test results _____ ☐
5. Biopsy report _____ ☐
6. Others _____ ☐

I hereby authorize the release of all necessary medical records to **Natarajan Asokan, M.D**
3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
I wish for them to be forwarded as soon as possible.

Patient's Signature: _____ Date: _____
(or parent if patient is a minor)

Patient's Address: _____ City: _____ State: ____ ZIP Code: _____

Signature of Witness: _____

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PATIENT NAME: _____ DOB: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

E-Mail Consent

1. RISK OF USING E-MAIL

Dr. Asokan (Provider) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks the patient should consider before using e-mail. These include, but are not limited to the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an e-mail.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems without authorization or detection.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the medical record, such as staff and billing personnel will have access to those e-mails.
b. Provider may forward e-mails internally to provider's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. Although Provider will endeavor to read and respond promptly to e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
d. If the patient's e-mail requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
f. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
g. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:
a. Limit the number of e-mails sent to a reasonable minimum
b. Avoid use of his/her employer's computer and employer provided e-mail address.
c. Inform Provider of changes in his/her e-mail address.
d. Put the patient's name in the body of the e-mail.
e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
f. Review the e-mail to make sure it is clear, brief and that all relevant information is provided before sending to Provider.
g. Inform Provider that the patient received an e-mail from Provider
h. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
i. Withdraw consent only by e-mail or written communication to Provider.

4. **PATIENT ACKNOWLEDGMENT AND AGREEMENT**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between provider and me, and consent to the conditions outlined herein. In addition, I agree to instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

PATIENT'S or LEGAL GUARDIAN'S

SIGNATURE:_____

DATE: _____

WITNESS
SIGNATURE:_____

DATE: _____

Please read carefully, sign & date and submit by fax, mail or in person. Further e-mail communication is not possible without completion of this step. Ask if you have questions.

Trinity Allergy, Asthma and Immunology Care, P.C.

Natarajan Asokan, M.D.

Diplomate of American Board of Allergy & Immunology

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www.trinityallergy.com

PERMISSION TO BILL

I authorize **Trinity Allergy, Asthma, and Immunology Care, PC** to release information regarding my care to the insurance I have on file. I certify that the information provided is true and accurate. I assign any payable benefit to **Trinity Allergy, Asthma, and Immunology Care, PC** and authorize them to submit claims on my behalf and release any information required to obtain payment for my care and treatment. I understand that I am financially liable for any non-covered service.

Printed Name:_____

Signature: _____

Date:_____

Relationship to Patient: _____

MEDICATION HISTORY CONSENT FORM

By signing below I give permission for **Trinity Allergy Asthma and Immunology Care, P.C.** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Trinity Allergy Asthma and Immunology Care, P.C.** to:

• Determine the pharmacy benefits and drug co pays for a patient's health plan.

• Check whether a prescribed medication is covered (in formulary) under a patient's plan.

• Display therapeutic alternatives with preference rank (if available) within a drug class for medications.

• Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

• Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Printed Name:_____

Signature: _____

Date:_____

Relationship to Patient: _____

TRINITY ALLERGY, ASTHMA AND IMMUNOLOGY CARE, P.C.

NATARAJAN ASOKAN, M.D.

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
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WWW.TRINITYALLERGY.COM

Notice of privacy practices

The notice of privacy practices is required by the Privacy Regulations created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this practice) may be used and disclosed, and how you can access to your individually identifiable health information.

Please Review This Notice Carefully

1. **Our commitment to your privacy**

   Our Practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy that we have in effect at the time.

   We realize that these laws are complicated, but we must provide you with the following important information:

   How we may use and disclose your IIHI
   Your privacy rights in your IIHI
   Our obligations concerning the use and disclosure of your IIHI

   The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

2. If you have questions about this notice, please contact:

The Privacy Officer at: **Trinity Allergy, Asthma and Immunology Care, P.C.,** 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801

3.We may use and disclose your IIHI in the following ways:

The following categories describe the different ways in which we may use and disclose your IIHI.

Treatment. Our practice may use your IIHI to treat you. For example we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your IIHI to bill you directly for service and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

4. Use and disclosure of your IIHI in certain special circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- ❑ Maintaining vital records, such as births and deaths
- ❑ Reporting child abuse or neglect
- ❑ Notifying a person regarding potential exposure to a communicable disease
- ❑ Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- ❑ Reporting reactions to drugs or problems with products or devices
- ❑ Notifying individuals if a product or device they may be using has been recalled
- ❑ Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- ❑ Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- ❑ Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- ❑ Concerning a death we believe has resulted from criminal conduct.
- ❑ Regarding criminal conduct at our offices.
- ❑ In response to a warrant, summons, court order, subpoena or similar legal process.
- ❑ To identify/locate a suspect, material witness, fugitive or missing person.
- ❑ In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity or location of the perpetrator).

Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain written authorization to use your IIHI for research purposes except when Internal Review Board of Privacy Board has determined that the waiver of your authorization satisfies the following:

(i) the use or disclosure involves no more than a minimal risk to your privacy based on the following:

a. An adequate plan to protect the identifiers from improper use and disclosure;

b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and

c. Adequate written assurances that the IIHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(ii) the research could not practicably be conducted without the waiver; and

(iii) the research could not practicably be conducted without access to and use of the IIHI.

Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

5. Your Rights Regarding Your IIHI

You have the following rights regarding the IIHI that we maintain about you:

Confidential Communication. You have the 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. In order to request a type of confidential communication, you must make a written to the Privacy Officer at: **Trinity Allergy, Asthma and Immunology Care, P.C.,** 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801 specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate *reasonable* requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.**

Your request must describe in a clear and concise fashion:

- ❑ the information you wish restricted;
- ❑ whether you are requesting to limit our practice's use, disclosure or both; and
- ❑ to whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and correct; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented (for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim). In order to obtain an accounting of disclosures, you must submit your request in writing to: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy

practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.** .

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time ***in writing***. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note we are required to retain records of your care.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.**

TRINITY ALLERGY, ASTHMA AND IMMUNOLOGY CARE, P.C.

NATARAJAN ASOKAN, M.D.

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200
285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800
WWW.TRINITYALLERGY.COM

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of the Notice of Privacy Practices.

Signature of Patient:_____ Date: _____

Signature of Guardian: _____ Date: _____

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FINANCIAL POLICY NOTIFICATION

Thank you for selecting us as your health care provider. We are committed to your successful treatment. The following is a statement of our Financial Policy. Please read all sections of the policy. If you have any questions or concerns, contact our business office at 928-681-5000. We require this notification to be completed annually prior to the provision of any services.

UNLESS YOU ARE A MEMBER OF ONE OF OUR CONTRACTED PLANS, MEDICAID OR MEDICARE, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD FOR YOUR CONVENIENCE.

CONTRACTED PLANS

Even if Trinity Allergy, Asthma and Immunology Care, P.C.is contracted with your health plan, the majority of members are still required to make some type of payment for service(s) rendered. This patient liability may be in the form of a co-payment, deductible, and/or co-insurance. If your plan has a co-payment, you will be expected to pay your co-payment prior to receiving any service including an office visit and/or immunotherapy. If you have a high deductible plan, you will be required to pay a minimum of 50% at the time of service until we verify your deductible has been made. Co-payments, deductibles, and co-insurance are requirements of your insurance plan not Trinity Allergy, Asthma and Immunology Care, P.C. We are required under our contract with these plans to collect these amounts from you.

POS AND HMO PLANS

Most of these plans require that you obtain a referral from your primary care physician prior to receiving any services in our office. If you do not obtain a referral from your primary care physician prior to receiving services, or a referral cannot be verified by our business office, you have the option of rescheduling your appointment or immunotherapy services. If you keep your appointment and/or receive services in our office it is with the understanding that your health plan may not pay for charges related to the services provided by Trinity Allergy, Asthma and Immunology Care, P.C. and that without a referral you will be responsible for payment of all charges.

SELF PAY/NON-CONTRACTED PLANS

Payment is due at the time of service unless prior financial arrangements have been made with our business office. All previous balances are expected to be paid in full prior to new services being rendered.

DIVORCE SITUATIONS

We look to the adult who has brought the child in for the appointment to be responsible for payment of the services which are rendered to the child. We expect the parents to be able to work out payment arrangements with one another. Our office staff will not participate in any disputes which may arise with respect to financial liability or responsibility.

COLLECTIONS

Should it become necessary for Trinity Allergy, Asthma and Immunology Care, P.C.to utilize the services of an outside collection agency in order to collect the amounts which are due from and owed by you, you may be held liable for collection agency fees and/or attorney fees. The credit agency used by Trinity Allergy, Asthma and Immunology Care, P.C. reports to all three credit bureaus.

I have read the above Trinity Allergy, Asthma and Immunology Care, P.C.Financial Policy Notification and understand my financial responsibility with Trinity Allergy, Asthma and Immunology Care, P.C.I hereby affix my signature as an acknowledgement of this understanding.

_____
Print Patient Name

_____ _____
Patient/Responsible Party Signature Date

Trinity Allergy, Asthma and Immunology Care, P.C.

Natarajan Asokan, M.D.

Diplomate of American Board of Allergy & Immunology

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285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

www.trinityallergy.com

No Show Policy

I understand it is Trinity Allergy, Asthma and Immunology Care, P.C's policy that I will be charged $25.00 for any no show for a scheduled appointment and failing to show up for the appointment without canceling or rescheduling the appointment at least 24 hours before the appointment time. I understand it is my responsibility to cancel or reschedule any appointment that I made with the office at least 24 hours before the scheduled appointment time. This consent is good without any time limit.

Patient's Name **Patient/Guardian's signature** **Date**

Trinity Allergy, Asthma and Immunology Care, P.C.

Natarajan Asokan, M.D.

Diplomate of American Board of Allergy & Immunology

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Medications to stop before allergy skin test appointment

Antihistamines including prescription and over the counter ones will negatively affect the outcome of skin tests. These medications have to be stopped as outlined below before you show up for a skin test appointment. As the skin tests are usually done on the same day as your first visit to our office, it is important that you consider the information below before scheduling an appointment. Remember many over the counter cold and cough medications, sleep-aids, acid reducers/ heartburn medications and eye drops contain antihistamines and have to be stopped as well before skin test appointment. If you are not sure about the nature of your medications, please check with your pharmacist. Get permission from your doctor before stopping your or your child's medications. If the antihistamine medications are not stopped required number of days before the appointment, you will not be able to complete the skin test on the day of appointment and the test may have to be postponed or other options may be considered.

- **Stop these oral antihistamines for 7-10 days before your appointment:**
  - ☒ Alavert® (Loratadine)
  - ☒ All Antihistamine Allergy Relief Eye Drops (Patanol, Pataday, Optivar, Azelastine, Zaditor etc. Call us if you are not sure). DO NOT STOP GLAUCOMA DROPS.
  - ☒ Allegra® (Fexofenadine)
  - ☒ Astelin or Astepro ® nasal spray (Azelastine nasal spray)
  - ☒ Astelin® (Azelastine)
  - ☒ Clarinex® (Desloratadine)
  - ☒ Claritin® (Loratadine)
  - ☒ Dymista® nasal spray
  - ☒ Loratadine (Claritin, Alavert)
  - ☒ Xyzal® (levocetirizine)
  - ☒ Zyrtec® (Cetirizine)
- **Stop these oral antihistmanines for 4 days before your appointment:**
  - ☒ Actifed
  - ☒ Antihist
  - ☒ Atarax®, Vistaril® (Hydroxyzine)

- ☒ Azatadine (Optimine, Trinalin)
- ☒ Benadryl (Diphenhydramine)
- ☒ Bromfed
- ☒ Brompheniramine
- ☒ Cabinoxamine (Rondec)
- ☒ Chlopheniramine (Chlortrimeton)
- ☒ Clemastine (Tavist)
- ☒ Cyproheptadine (Periactin)
- ☒ Deconamine
- ☒ Desloratidine (Clarinex)
- ☒ Dimenhydrinate (Dramamine)
- ☒ Dimetapp
- ☒ Diphenhydramine (Benadryl)
- ☒ Diphenylpyraline (Hispril)
- ☒ Doxylamine (Bendectin, Nyquil)
- ☒ Drixoral
- ☒ Dura-tab
- ☒ Hydroxyzine (Atrax, Vistaril, Marax)
- ☒ Kronofed
- ☒ Meclizine (Antivert)
- ☒ Methdilazine HCl (Tacaryl)
- ☒ Naldecone
- ☒ Novafed-A
- ☒ Ornade
- ☒ Phenergan (Promethazine)
- ☒ Phenindamine (Nolamine, Nolahist)
- ☒ Pheniramine (Polyhistine D)
- ☒ Poly-Histine-D
- ☒ Promethazine HCl (Phenegan)
- ☒ Pyrilamine (Kronohist, Rynatan)
- ☒ Rynatan
- ☒ Tavist
- ☒ Trimeprazine (Temaril)
- ☒ Trinalin
- ☒ Triprolidine (Actifed)

❖ If you are taking an **oral** antihistamine that is not listed above stop the medicine for **3-4 days** before your appointment. If you are not sure if the medicine you are taking is an antihistamine, ask your doctor or pharmacist.

❖ **<u>Stop these medications 1-2 days before your appointment:</u>**

- ☒ Axid® (nizatidine)
- ☒ Pepcid® (famotidine)
- ☒ Tagamet® (cimetidine)
- ☒ Zantac® (ranitidine)

- Some **antidepressants** can also act as antihistamines. Let us know if you are on any antidepressants before skin testing. **Do not stop antidepressants** for any reason without checking with your doctor first.
- **The following medications should not be stopped:**

  Do not stop any of your asthma medications or inhalers.

  - ☒ Cromolyn (Intal) and Nedocromil (Tilade),
  - ☒ Inhaled (Beconase, Vancenese, Nasalide, Fluticasone, Nasacort, Beclovent, Vanceril, Aerobid, Azmacort, Pulmicort, Flovent, Qvar, Symbicort, Dulera, Advair)
  - ☒ Oral Corticosteriods (Prednisone, Medrol)
  - ☒ Pseudoephedrine
  - ☒ Theophylline

Continue to take all your other medications as you normally do. Do not stop any medication without checking with your doctor first. Usually we do control skin tests first before doing full panel skin tests to ensure that your body does not have any interfering medications at the time of testing. If you are not sure about the need for stopping a medication, please call our office or the prescribing physician's office before you stop them.

If you have questions, please call our office for clarification at 928-681-5800.