Trinity Allergy, Asthma and Immunology Care, P.C.
3178 Western Ave #A, 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

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**
3178 Western Ave #A, 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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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: _____

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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: _____

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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

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of **TRINITY ALLERGY ASTHMA AND IMMUNOLOGYCARE, P.C.**'s Notice of Privacy Practices, which has an effective date **of 8/15/2017**, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Patient's Representative Date

_____

Print Name

_____

Relationship to Patient (If not signed by the Patient)