

REGISTRATION FORM

Today's date:				PCP:									
PATIENT INFORMATION													
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status							
						<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Other					
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F					
Street address:			Social Security Number :			Cell phone:							
P.O. box:		City:		State:		ZIP Code:							
Occupation:		Employer:			Employer phone:								
How did you hear about our Clinic?													
<input type="checkbox"/>	Referred by Doctor	<input type="checkbox"/>	Family	<input type="checkbox"/>	Friend	<input type="checkbox"/>	Vehicle	<input type="checkbox"/>	Social Media	<input type="checkbox"/>	Billboard	<input type="checkbox"/>	Other _____
Patient Email Address:													
INSURANCE INFORMATION													
(Please give your insurance card to the receptionist.)													
Person responsible for bill:		Birth date:		Address (if different):			Home phone #:						
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Occupation:		Employer:		Employer address(city,state,zip):			Employer phone #:						
Is this patient covered by <input type="checkbox"/> Yes <input type="checkbox"/> No insurance?													
Please indicate primary insurance													
<input type="checkbox"/>	BC/BS	<input type="checkbox"/>	United Health	<input type="checkbox"/>	Aetna	<input type="checkbox"/>	Cigna	<input type="checkbox"/>	Coventry	<input type="checkbox"/>	Wed TPA	<input type="checkbox"/>	Other _____
Subscriber's name:		Subscriber's SSN:		Birth date:		Group #:	Policy #:	Co-pay: \$					
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other													
Name of secondary insurance (if applicable):		Subscriber's name:			Group #:		Policy #:						
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other													
IN CASE OF EMERGENCY													
Name of local friend or relative (not living at same address):				Relationship to patient:		Cell phone:	Work phone:						
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 [Name of Practice] or insurance company to release any information required to process my claims.													
Patient/Guardian signature						Date							

HIPAA CONSENT

My signature on this form indicates that I want to receive appointment conformation via text and have received the Notice of Privacy Practice for the Oklahoma Institute of Allergy Asthma & Immunology located on last 3 pages.

If I have any questions, I know to contact the Privacy Officer whose information is provided to me in the Notice of Privacy Practices. I also consent to the use and disclosure of my protected health information for my treatment, payment and operational use.

Name:	Signature:	Date:
Name of Personal Representative (if different from above)		
Name:	Signature:	Date:
Relationship to patient:		

Release of information to Insurance

I authorize release of any information concerning me (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to the doctor.

Signature:	Date:
------------	-------

Scheduling Policy

Due to the high demand of our specialty, all appointments must be confirmed no less than 24 hours before scheduled appointment. If not confirmed, appointment is subject to cancellation. You can confirm appointments by phone or by replying to Text Confirmation.

New Patients: For cancellation less than 24 hours or "No Show" to scheduled appointment will result in a \$150 fee. (By scheduling an appointment patient agrees to terms)

Established Patients: For cancellation less than 24 hours or "No Show" to scheduled appointment will result in a \$75 fee. (By scheduling appointment patient agrees to terms)

Patient Acknowledgment

Signature:	Date:
------------	-------

No Show Policy

Patient Name:
Date of Birth:
Today's Date:

Dear Patients and Parents,

Oklahoma Institute of Allergy, Asthma & Immunology is an extremely busy clinic due to the nature of our specialty in Oklahoma. We ask that you please give at least a 24 hour notice if you will not be able to make your scheduled appointment.

Due to the number of patients we see every day and the amount of patients on our waiting list we take "NO SHOW" appointments seriously. When you "NO SHOW" an appointment your next appointment will be scheduled at the first available time slot, not worked in. This document is to inform you that if you "NO SHOW" an appointment you are taking a risk of not being able to schedule future appointment with this office.

By signing below you are acknowledging you have read this policy.

Patient or Guardian Signature: _____

Date: _____

Financial Agreement

Payment is due at time of service.

Allergy Serum must be paid for prior to mixing.

Patient is subject to prior Authorization fees for medication.

Patient is responsible for all charges. If patient account balance is not paid in full within 120 days we reserve the right to send the account to a collections agency. If the account goes to a collection agency 30% of the balance will be added to the account.

We offer multiple forms of payment: Cash, Check, VISA, MasterCard, Discover, and Care Credit.

Name:

Signature:

Date:

Authorization for Release of Medical Information Regarding Patient

Patients Name:

I hereby give my permission for medical information to be released to:

Name as shown on ID:

Relationship to patient:

Please note: If adopted, proof of adoption is required.

Step-Parents are unable to sign for consents without proper paperwork showing guardianship.

Grandparents are unable to sign for consents without proper paperwork showing guardianship.

If parents are divorced, proof of medical guardianship is required.

I authorize **Oklahoma Institute of Allergy and Asthma** to leave a voicemail or verbal message regarding appointment information, results of lab work, follow-up inquiries, billing, and insurance questions and statements.

YES

NO

Signature:

Date:

Acknowledgment of Receipt of Notice of Privacy Practices and Consent for Treatment, Healthcare operations.

My signature on this form indicates that I have received the Notice of Privacy Practice for the Oklahoma Institute of Allergy Asthma & Immunology. If I have any questions, I know to contact the Privacy Officer whose information is provided to me in the Notice of Privacy Practices. I also consent to the use and disclosure of my protected health information for my treatment, payment and operational use.

Patient/Guardian Signature:

Date:

New Patient Questionnaire

Patient Name:

Please read carefully and complete the questionnaire. Please print legibly. Answers should be your own thoughts and experiences. Not just based off previous testing. Please circle or fill in the blanks accordingly. All information will be considered confidential.

Current Medications:

Please list **ALL** medications currently taking and the dosage including OTC medications, or provide a list so we may scan into your chart.

Allergies: Please list all the apply and what type of reaction

Medications:

Foods:

Previous Allergy Evaluation

When:

Who:

Have you had allergy shots?

Were they helpful?

How long were you on them?

Yes No

Yes No

Nasal History

<input type="checkbox"/> Itching	<input type="checkbox"/> Sneezing	<input type="checkbox"/> PND	<input type="checkbox"/> Congestion	<input type="checkbox"/> Loss of smell
<input type="checkbox"/> Snoring	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Nose surgery	<input type="checkbox"/> Nose Trauma	<input type="checkbox"/> Runny Nose

What month's symptoms are the worst?

<input type="checkbox"/> Jan	<input type="checkbox"/> Feb	<input type="checkbox"/> Mar	<input type="checkbox"/> Apr	<input type="checkbox"/> May	<input type="checkbox"/> Jun
<input type="checkbox"/> Jul	<input type="checkbox"/> Aug	<input type="checkbox"/> Sep	<input type="checkbox"/> Oct	<input type="checkbox"/> Nov	<input type="checkbox"/> Dec

Nasal Triggers

<input type="checkbox"/> Cleaning products	<input type="checkbox"/> Detergents	<input type="checkbox"/> Cooking odors	<input type="checkbox"/> Perfume/cologne	<input type="checkbox"/> Tobacco Smoke
<input type="checkbox"/> Powder	<input type="checkbox"/> Moth balls	<input type="checkbox"/> Motor fumes	<input type="checkbox"/> Paint lacquer	<input type="checkbox"/> Wax
<input type="checkbox"/> Insect spray	<input type="checkbox"/> Chemicals	<input type="checkbox"/> Fertilizers	<input type="checkbox"/> Ammonia	<input type="checkbox"/> Room deodorants

<input type="checkbox"/> Bleach	<input type="checkbox"/> Glue	<input type="checkbox"/> Soap	<input type="checkbox"/> Shampoo	<input type="checkbox"/> Shaving cream
<input type="checkbox"/> After shave	<input type="checkbox"/> Spray deodorant	<input type="checkbox"/> Hair spray	<input type="checkbox"/> Hair dye	<input type="checkbox"/> Hand lotions
<input type="checkbox"/> Nail polish	<input type="checkbox"/> Dogs	<input type="checkbox"/> Cats	<input type="checkbox"/> Equine	<input type="checkbox"/> Cattle
<input type="checkbox"/> Rodents	<input type="checkbox"/> Hot	<input type="checkbox"/> Cold	<input type="checkbox"/> Humidity	<input type="checkbox"/> Damp
<input type="checkbox"/> Smog	<input type="checkbox"/> Sunlight	<input type="checkbox"/> A/C	<input type="checkbox"/> Change in temp.	<input type="checkbox"/> Rain.
Other Nasal Triggers:				

Eye History

<input type="checkbox"/> Tearing	<input type="checkbox"/> Burning	<input type="checkbox"/> Itching	<input type="checkbox"/> Pain	<input type="checkbox"/> Redness
<input type="checkbox"/> Puffiness	<input type="checkbox"/> Infection	<input type="checkbox"/> Discharge	<input type="checkbox"/> Blurry	<input type="checkbox"/> Dryness
Other:				

Ear History

<input type="checkbox"/> Pressure	<input type="checkbox"/> Itchy	<input type="checkbox"/> Drainage	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Swelling	<input type="checkbox"/> Infections	<input type="checkbox"/> Tubes
Other:			

Tongue History

<input type="checkbox"/> Swollen	<input type="checkbox"/> Sore	<input type="checkbox"/> Itching	<input type="checkbox"/> Coated	<input type="checkbox"/> Trouble Tasting
Other:				

Mouth/Throat History

<input type="checkbox"/> Itchy	<input type="checkbox"/> Recurrent Tonsillitis	<input type="checkbox"/> Morning Sore Throat	<input type="checkbox"/> Postnasal Drip
<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Mouth Breathing/Bad Breath	<input type="checkbox"/> Frequent Throat Clearing	<input type="checkbox"/> Change in Voice
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Vomit Burps	<input type="checkbox"/> Pain
Other:			

Skin History (Check all that are bothersome when contacted)

<input type="checkbox"/> Wool	<input type="checkbox"/> Silk	<input type="checkbox"/> Sweater	<input type="checkbox"/> Shoes	<input type="checkbox"/> Dry Cleaning
<input type="checkbox"/> Starched	<input type="checkbox"/> Unwashed	<input type="checkbox"/> Cut Grass	<input type="checkbox"/> Flowers	<input type="checkbox"/> Plants
<input type="checkbox"/> Hay	<input type="checkbox"/> Christmas Tree	<input type="checkbox"/> Plastic	<input type="checkbox"/> Rugs	<input type="checkbox"/> Fiberglass
<input type="checkbox"/> Rubber	<input type="checkbox"/> Dust	<input type="checkbox"/> Feather Pillows	<input type="checkbox"/> Furs	<input type="checkbox"/> Jewelry

Other:

What activities cause a rash or skin irritation?

<input type="checkbox"/> Running	<input type="checkbox"/> Jumping	<input type="checkbox"/> Swimming	<input type="checkbox"/> Sports
----------------------------------	----------------------------------	-----------------------------------	---------------------------------

History of:

<input type="checkbox"/> Eczema	<input type="checkbox"/> Rashes	<input type="checkbox"/> Boils	<input type="checkbox"/> Infections	<input type="checkbox"/> Poison Ivy
---------------------------------	---------------------------------	--------------------------------	-------------------------------------	-------------------------------------

Eczema Rash Reaction if applicable

List of foods:

<input type="checkbox"/> Heat/Cold	<input type="checkbox"/> Pressure	<input type="checkbox"/> Scratching	<input type="checkbox"/> Sunlight
<input type="checkbox"/> Exercise	<input type="checkbox"/> Grass	<input type="checkbox"/> Tight Clothing	<input type="checkbox"/> Other

Chest/Lung History

<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Tightness
<input type="checkbox"/> Childhood Asthma	<input type="checkbox"/> Frequent Bronchitis	<input type="checkbox"/> Cough
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Difficulty getting air	<input type="checkbox"/> Gradual worsening of symptoms
<input type="checkbox"/> Sudden worsening of symptoms	<input type="checkbox"/> Voice change with shortness of breath	<input type="checkbox"/> Blockage of air flow in chest or lungs
Do you use a rescue inhaler?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does drinking water help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cough when laughing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you prefer an Inhaler or Nebulizer?	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Nebulizer
Do you use a spacer with your inhaler?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use a mask with spacer or inhaler?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you check peak flow?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have an Asthma Action plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any ER visits due to respiratory problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Medical History

Please list all surgeries and date of surgery (mm/yy):

Please list any hospital stay not related to surgeries:

Family Medical History

Father:

Mother:

Sister:

Brother:

Sons:

Daughters:

Other diseases that run in your family:

Social History

Any Smoke Exposure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How Long?
Do you Smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Packs a Day?
Have you ever Smoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How Long?
Do you drink Alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often?
Do you use recreational Drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often?

Environmental History

What type of home do you live in?				
<input type="checkbox"/> House	<input type="checkbox"/> Apartment	<input type="checkbox"/> Farm	<input type="checkbox"/> Manufactured	<input type="checkbox"/> Other
What type of heating?				
<input type="checkbox"/> Oil/Gas	<input type="checkbox"/> Electric	<input type="checkbox"/> Coal	<input type="checkbox"/> Gas Fireplace	<input type="checkbox"/> Wood Fireplace
Type of A/C				
<input type="checkbox"/> Central	<input type="checkbox"/> Window Unit	<input type="checkbox"/> Fan		
Do you live near a Farm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you use a humidifier?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you use a HEPA filter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Any of the following in the house?				
<input type="checkbox"/> Book Shelf	<input type="checkbox"/> Ceiling Fans	<input type="checkbox"/> Stuffed Animals		
Any history of water leaks in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
What type of flooring in the home?				
<input type="checkbox"/> Carpet	<input type="checkbox"/> Wood	<input type="checkbox"/> Laminate	<input type="checkbox"/> Tile	<input type="checkbox"/> Other
Do you have dust mite covers on pillows & mattress?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Do you have pets?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
How many pets if applicable?	_____ Dogs		_____ Cats	
How long have you lived in Oklahoma?				
List any other State you have lived in.				

Sleep Questionnaire

This short self-evaluation questionnaire will assist your physician in the assessment of your risk for Obstructive Sleep Apnea (OSA). OSA is a sleep disorder which is diagnosed by pauses in normal patterns of breathing while you are asleep. OSA has been strongly linked to numerous medical conditions to include heart disease, diabetes, lung disease, vascular disorders, psychiatric conditions and can markedly increase surgical risks in certain populations. If your screening questionnaire suggests you may be at risk for a sleep disorder, your physician may discuss options with you to further evaluate your risk profile.

Please answer all of the following questions by selecting "YES" or "NO"

S (snoring) Have you ever been told you snore loudly?		
T (tired) Are you often "tired" or sleepy during the day?		
O (obstruction) Have you ever awakened suddenly from sleep gasping for air? Or has anyone witnessed you stop breathing while you are asleep?		
P (pressure) Have you ever been diagnosed with high blood pressure or are you taking medication for high blood pressure?		
B (BMI) Is your body mass index greater than 30? Weight____ Height____ (**If you are unsure of your BMI, simply provide your height and weight so your healthcare provider can calculate.**)		
A (age) Are you 50 years old or older?		
N (neck) Are you a male with a neck circumference larger than 17 inches, or female with a neck circumference larger than 16 inches?		
G (Gender) Are you a male?		

Number of "Yes" responses: _____ / (8 possible)
(High Probability of Obstructive sleep apnea diagnosis with 3 or more "YES" responses)

Thank you for completing this questionnaire regarding your overall sleep quality. Your physician may discuss options for further evaluation of your sleep if your profile suggests you may be at risk for a sleep disorder.

Headache Questionnaire

Does not apply to me

Do you know what might be causing your headache?		
<input type="checkbox"/> Sinus Pressure	<input type="checkbox"/> HTN	<input type="checkbox"/> Whiplash
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Other
Has this type occurred before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is headache pain unbearable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your neck, shoulders, or head junction feel tight during headache?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your headache pain dull and steady like constant pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your headache feel like a tight band around your head?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you usually have more than one headache a week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your headaches occur during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does any blood relative have similar headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does exertion affect your headache?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does nausea or vomiting occur before or during your headache?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have vision change with headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your headache usually start on one side of your head?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your headache throb, pulsate, or feel like its pounding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your headache occur during the night or upon awakening?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your headaches occur during weekends and holidays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your headache associated with your menstrual cycle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have watering of the eye on the affected side?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does alcohol cause or aggravate your headache?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do any foods cause or worsen your headache?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any hearing problems with headache?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any facial pain, aching jaw, stuffiness or congested sinuses along with headache?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has it been over 18 months since your last dentist appt.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any test for headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list any previous headache medication: (Rx and OTC)

Have you had any of the following problems :

<input type="checkbox"/> Paralysis	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Swallowing	<input type="checkbox"/> Speech
------------------------------------	--	-------------------------------------	---------------------------------

Hives Questionnaire

Does not apply to me

Date of onset hives?		Date:		
Frequency of attacks?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
Time of day when they happen?	<input type="checkbox"/> Morning	<input type="checkbox"/> Daytime	<input type="checkbox"/> Evenings	<input type="checkbox"/> After meals
Seasonal:	<input type="checkbox"/> Winter	<input type="checkbox"/> Aug-Sept	<input type="checkbox"/> Spring	<input type="checkbox"/> Summer
Physical:	<input type="checkbox"/> Heat	<input type="checkbox"/> Exercise	<input type="checkbox"/> Sunlight	<input type="checkbox"/> Rainy
<input type="checkbox"/> Damp	<input type="checkbox"/> Bathing	<input type="checkbox"/> Pressure	<input type="checkbox"/> Prolonged Sitting	<input type="checkbox"/> Vibration
<input type="checkbox"/> Rubbing	<input type="checkbox"/> Scratching	<input type="checkbox"/> Friction	<input type="checkbox"/> Clothing	<input type="checkbox"/> Other
Contact:	<input type="checkbox"/> Animals	<input type="checkbox"/> Soaps	<input type="checkbox"/> Detergent	<input type="checkbox"/> Other
Hormonal:	<input type="checkbox"/> Stress	<input type="checkbox"/> Menstrual	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Other
Occupational:	<input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Work	<input type="checkbox"/> Home
<input type="checkbox"/> Anywhere	<input type="checkbox"/> Weekends	<input type="checkbox"/> Vacations	<input type="checkbox"/> Housework	<input type="checkbox"/> Other
Foods:	<input type="checkbox"/> Beer	<input type="checkbox"/> Bread	<input type="checkbox"/> Cake	<input type="checkbox"/> Cheese
<input type="checkbox"/> Cider	<input type="checkbox"/> Coffee	<input type="checkbox"/> Eggs	<input type="checkbox"/> Grapes	<input type="checkbox"/> Ham
<input type="checkbox"/> Pork	<input type="checkbox"/> Ketchup	<input type="checkbox"/> Milk	<input type="checkbox"/> Mints	<input type="checkbox"/> Nuts
<input type="checkbox"/> Pickles	<input type="checkbox"/> Seafood	<input type="checkbox"/> Strawberries	<input type="checkbox"/> Tomatoes	<input type="checkbox"/> Wine
<input type="checkbox"/> Vinegar	<input type="checkbox"/> Sausage	<input type="checkbox"/> Kiwi	<input type="checkbox"/> Cucumber	<input type="checkbox"/> Other
Treatments Tried for Clearing Hives: Rate medications 0=none, 1=Slight, 2=Moderate, 3=Clear				
<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Zyrtec/Cetizine	<input type="checkbox"/> Benadryl		
<input type="checkbox"/> Atarax	<input type="checkbox"/> Hydroxyzine	<input type="checkbox"/> Singulair		
<input type="checkbox"/> Steroids	<input type="checkbox"/> Prednisone	<input type="checkbox"/> Solumedrol		
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Montelukast	<input type="checkbox"/> Other		
Diet Elimination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
What foods?				
Antibiotic Elimination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
What Antibiotics?				
Other Eliminations?				

Notice of Privacy Practices

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.

The Oklahoma Institute of Allergy & Asthma is committed to protecting the privacy of your medical information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. This notice describes your rights and our legal duties regarding your Protected Health Information (“PHI”). “Protected Health Information” is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. In this notice, we call that protected information, “medical information”.

HOW THIS MEDICAL PRACTICE MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION

Treatment. We will use your medical information to treat you. For example, we may disclose your medical information to other doctors, nurses, technicians, medical students, or other members of our staff who are involved in taking care of you or to other care professionals for additional treatment or follow up care such as home health services. We also may disclose your medical information to people outside our medical practice who may be involved in your care such as your family members.

Payment. We may use and disclose your medical information to receive payment for our services from you, an insurance company or a third party. For example, we may need to give your health plan information about a procedure we perform at our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose your medical information to operate this medical practice. For example, we may use this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also share your medical information with our business associates, such as a billing service, that perform administrative services for us. We have a written contract with each business associate that contains terms requiring them to protect the confidentiality of your medical information.

Appointment Reminders. We may use and disclose your medical information to remind you about appointments.

Sign-in Sheet. We may use and disclose your medical information by having you sign in when you arrive at the clinic.

Notification and Communication with Family. We may disclose your medical information to notify or assist a family member, or another person who is involved in your care unless you ask us not to. In the event of a disaster, we may disclose information to a relief organization, such as the Red Cross, so that they may

Coordinate these notification efforts. We may also disclose information to someone who pays for your care. If you are unable to agree or object to these disclosures, our health professionals will use their best judgment in communicating with your family and others.

With Your Authorization. We may disclose your medical information for purposes not described in this notice or otherwise permitted by law only with your written authorization. You may revoke an authorization at any time, in writing, but only as to future uses or disclosures, and only where we have not already acted in reliance on your authorization. Revocations should be delivered to the Clinic Privacy Officer.

Required by Law. We may use and disclose your medical information when required to do so by law, but only to the extent and under the circumstances provided in that law.

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

Public Health and Safety. Your medical information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability; to report birth defects or infant eye infections; to report cancer diagnoses and tumors; to report child abuse or neglect or child born with alcohol or other substances in its system; to report reactions to medications or problems with products; to notify you of recalls of products you may be using; to notify the Oklahoma State Department of Health that a person may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition such as HIV, syphilis, or other sexually transmitted diseases; or to notify the appropriate governmental authority if we believe a patient has been the victim of abuse, neglect, or domestic violence, if the victim agrees to our reporting or if we are required to do so by law. Your medical information may be disclosed to appropriate persons in order to prevent or lessen a serious and imminent threat to you or to the health and safety of a particular person or the general public.

Specializing Government Functions. We may disclose your medical information for military or national security purposes, national intelligence, protection of the President, or to correctional institutions or law enforcement officers that have you in their lawful custody.

Military. If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities necessary for the government to monitor the health care system, government programs, and compliance with applicable laws. These oversight activities include, for example, audits, investigations, inspections, medical device reporting and licensure.

Coroners/Funeral Directors. We may disclose your medical information to coroners in connection with their investigations of death or to funeral directors to enable them to carry out their lawful duties.

Organ or Tissue Donation. We may disclose your medical information to organizations involved in procuring, banking or transplanting organs, eyes and tissues, as necessary to facilitate organ, eye or tissue donation or transplantation.

Workers' Compensation. Your medical information may be used or disclosed as required by law related to workers' compensation.

Law Enforcement. Your medical information may be disclosed to law enforcement authorities to identify or locate suspects, fugitives or witnesses, or victims of crime (with your consent in some circumstances) and to report possible deaths caused by criminal activities or to report crimes on the premises.

Research. We may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information and has approved the research.

By Oklahoma law we are required to notify you that your medical information used or disclosed as described in this Notice of Privacy Practices may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

YOUR MEDICAL INFORMATION RIGHTS

You have the right:

- To receive a paper copy of this *Notice of Privacy Practices*.

- To request restrictions on certain uses and disclosures of your medical information by written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision. If we agree to a restriction, we may disregard it if the information is needed to provide you emergency treatment.

- To request that you receive medical information in a specific way or at a specific location. For example, you may ask that we send information to your work address. We will comply with all reasonable requests submitted.
- To review and obtain an electronic or paper copy of your medical information, with limited exceptions defined by law.

- To receive an accounting of disclosures made of your medical information by this medical practice unless the disclosures were for purposes of treatment, payment, health care operations, certain government functions, or pursuant to your written authorization.

Contact:

If you would like to have a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact the Privacy Officer.

Changes to this Notice: We reserve the right to change or amend this *Notice of Privacy Practices* at any time in the future. After an amendment is made, the revised *Notice of Privacy Practices* will apply to all protected health information that we maintain. A copy of any revised *Notice of Privacy Practices* will be made available to you at each appointment.