CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(This form applies only to the use, release and disclosure of information. It is not consent for treatment or intended for any other purpose.)

By signing this form, I consent to the use and release of all or any portion of the information obtained by Allergy and Asthma Consultants, P.C., as part of medical services provided to me for purposes of :

- **Diagnosis, treatment and care** (including information disclosed to appropriate personnel at Allergy and Asthma Consultants, P.C; other physicians, including those at other medical practices; laboratories; diagnostic centers; hospitals, other health care professionals, facilities and providers etc.
- **Obtaining Payment for Health Care Services** (filing insurance claims, collections, etc.)
- **Health care Operations** (this is a term used in federal privacy protection legislation that relates to quality control and review, business operations, general administrative purposes, and compliance with state and federal laws, etc.)

This consent for use/disclosure of protected health information does not apply to disclosure for other purposes, in which case Allergy and Asthma Consultants, P.C. will obtain specific authorization from me. There are a few exceptions in the law permitting use/disclosure of information without my authorization. Please see the *Notice of Privacy Practices* for details.

I understand that Allergy and Asthma Consultants, P.C. assumes no responsibility for the use or misuse *by others* of my health information disclosed under this consent.

I have been offered the opportunity to review Allergy and Asthma Consultants *Notice of Privacy Practices.* I have discussed any concerns that I may have about the use/disclosure of my health information with the Privacy Officer at Allergy and Asthma Consultants, P.C., or other appropriate personnel.

I release Allergy and Asthma Consultants, P.C. from all legal liability that may arise from this consent specifically with regard to the way my information is used by entities other than Allergy and Asthma Consultants, P.C. *provided that my information is utilized only as outlined above.*

Patient Signature: _____ Date: _____

If the signature above is not that of the patient, I am acting for them because

_____.

My relationship to the patient is: _____

Signed: _____ Date: _____

Revised 4/09

Account # _____ Insurance Code: _____

ALLERGY AND ASTHMA CONSULTANTS, P.C.

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(770) 740-9600
Fax: (770) 740-9306

Building A, Suite A
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Duluth, Georgia 30096
(770) 813-0254
Fax: (770) 813-0255

We appreciate the confidence you have expressed by selecting us as your physicians. If you have any questions about our services, fees, or other aspects of your care, please discuss them with us frankly. The best medical service is based on a friendly, mutual understanding between a doctor and his patients. Our office phone number is also our night and emergency phone. It is answered by our answering service when the office is closed. All patients are expected to pay for your portion of the bill including any copays and/or deductible. At the end of the month, you will receive an itemized statement showing the transactions of your account and the amount due, if any. If you are unable to pay your bill, please contact us and we will assist you in making arrangements for payment. If you are having temporary financial problems, let us know and we will be most understanding and cooperative.

PLEASE DISCUSS TOTAL COST OF A NEW PATIENT WORKUP WITH ME _____

Pharmacy #_____ TODAY'S DATE_____

PATIENT DATA

Patient Name _____ Sex_____

Address _____ Age_____

City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Home Phone# _____

Referred by and Services Requested by Dr. _____

Employer/School Name _____

Address _____

Child's Pediatrician_____ Other Physicians _____

Whom May We Thank for Referring Your child if not a Physician? _____

Address _____

We will be sending a report to your referring physician.
Please list any other physician(s) & address(es) to whom you would like a report of this visit sent. _____

_____

Has Any Member of Your Family Been Treated by Our Physicians? _____

Name _____ Relationship _____

OVER

* Whom Should We Contact in the Event of an Emergency?

Name _____ Phone #(s) (_____) _____

Phone #(s) (_____) _____

PARENT INFORMATION Parents are: Married _____ Divorced _____

Separated _____ Widowed _____

Father's Name _____ Home Phone _____

Home Address _____

Business Address _____ Business Phone _____

Employer _____ Position Held _____

Mother's Name _____ Home Phone _____

Home Address _____

Business Address _____ Business Phone _____

Employer _____ Position Held _____

GUARANTOR DATA

(Person Responsible for Bill if other than Self)

Name _____ Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

Home Phone # _____ Work Phone # _____

Employer Name _____

INSURANCE DATA

If you've had this insurance less than one year, your insurance became effective _____.

Primary Plan Name _____

Address _____

Insured Name _____ Relationship to Patient _____

Policy # _____ Group # _____

Secondary Plan Name _____

Address _____

Insured Name _____ Relationship to Patient _____

Policy # _____ Group # _____

(If Patient is a Minor, Parent or Guardian Signatures Required)

(1) **I authorize** the release of a report of diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to treatment, to the physicians listed, also any medical information may be sent to my insurance company.

_____ _____

Signature Date

(2) **Please sign** below to allow medical benefits to be paid directly to Allergy and Asthma Consultants, P.C.

_____ _____

Signature Date

(3) **Our office** will make every effort to comply with your insurance company's rules regarding our referring you or obtaining X-rays and laboratory studies. Due to our participation in over 30 different plans, each with its own regulations (and several companies have several different plans, of which all are different from each other), **WE CANNOT ASSUME ANY FINANCIAL RESPONSIBILITY FOR ERRORS.** It is your responsibility to know what your plan covers and what it does not cover.

_____ _____

Signature Date

Allergy & Asthma Consultants, P.C.

Date	Name	Age	Race	Sex

Referred By:	Primary Physician:	Date of Birth

My main concern and the main reason I am here is:	Date of Onset of Symptoms

SYMPTOMS: Please mark all the boxes that apply to you

__ Itchy Eyes
__ Watery Eyes
__ Red Eyes
__ Burning Eyes
__ Stuffy Nose
__ Itchy Nose
__ Sneezing — How many times in a row? _____
__ Runny Nose
__ Mucus in Throat
__ Frequent Nose Bleeds
__ Mouth Breathing
__ Snoring
__ Headaches
__ Pressure in Sinuses
__ Sinus Infections
__ Nasal Polyps
__ Pressure in Ears
__ Ear Infections

__ Cough: __ Frequent __ Productive of Sputum
__ Wheeze
__ Chest Tightness
__ Shortness of Breath
__ Exercise Limitation
__ Chest symptoms wake me up at night
__ Skin Rash
__ Eczema
__ Hives
__ Itching
__ Swelling
__ Indigestion or Heartburn
__ Rubber or Latex Allergy

PLEASE MARK THE SEASONS WHEN THE SYMPTOMS OCCUR:

	Nose/Hay Fever	Sinus	Eye	Chest/Asthma	Skin/Eczema or Hives	(Leave blank)
Year Round						
Spring						
Summer						
Fall						
Winter						

TRIGGERS: Please mark the things that make the symptoms Worse.

	Nasal/Sinus	Eye	Chest	Skin		Nasal/Sinus	Eye	Chest	Skin
Dusting or Vacuuming					Changes in Weather				
Cats					Changes in Temperature				
Dogs					Cigarette Smoke				
Other Animals					Odors & Perfume				
Foods					Cold Air				
Cut Grass					Air Conditioning				
Raked Leaves					Emotional Upset or Crying				
Hay					Exercise				
Dampness					Pregnancy or Menstruation				
Basements					Work or School				
Wet Weather					Other_____				

QUALITY OF LIFE: Please mark all that apply

__ Increased fatigue or lack of pep or energy
__ Affects work or school performance
__ Keeps me up at night
__ I feel less like exercising
__ Causes me to accomplish less than I would like to
__ I miss work or school due to my problem
__ This makes me nervous, irritable or unhappy
__ I get sick more that I should

PREVIOUS ALLERGY TESTING AND TREATMENT

Have you ever been Allergy Skin Tested? __ Yes __ No | Results of Testing _____
When and Where? _____ | Did you receive Allergy Injections? __ Yes __ No
What were the effects of injections on symptoms? __ Improved __ No Change __ Worsened __ Side Effects _____

What Other Health Problems Do You Have?

Please check and circle all that apply

__ Constitutional: Fatigue, Fever, Weight loss, Other
__ Cancer: type_____
__ CV: Heart Disease, High Blood Pressure, Murmurs, Other
__ Endocrine: Diabetes, Thyroid, Other
__ Ears-Nose-Throat: Sleep Apnea, Snoring, Other
__ Eyes: Cataracts, Glaucoma, Other
__ GI: Hepatitis, Hiatel Hernia, Irritable Bowel, Reflux, Ulcer, Other
__ Genito-Urinary: Bladder Infections, Kidney Disease, Other
__ Hematological (Blood): Anemia, Sickle Cell, Other
__ Muscule-Skeletal: Arthritis, Fibromyalgia, Other
__ Neurological: Epilepsy, Headache, Seizures, Strokes, Other
__ Psych: Alcohol or Drug Abuse, Anxiety, Depression, Other
__ Reproductive: Menopause, Other
__ Resp: COPD, Emphysema, PneumoniaTuberculosis, Other
__ Skin: Eczema, Rashes, Other
__ HIV, Aids

Review Of Systems

This column for Physicians Only

Yes	No
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—

MEDICATIONS: Please list all Prescription and Over the Counter Medications you are now taking.

Medication	Dose (mg)	How Often	Medication	Dose (mg)	How Often

Vitamins, Herbs and Other Supplements: Please list all that you are taking.

_____

Previous X-Rays

Have you had a Chest X-Ray? ___ Yes ___ No If Yes, When? _____ Where? _____

Have you had a Sinus X-Ray? ___ Yes ___ No If Yes, When? _____ Where? _____

HOSPITALIZATIONS OR SURGERIES; Please list all.

Problem or Operation	Age or Date	Problem or Operation	Age or Date

DRUG ALLERGIES: Please list all that apply to the patient

Drug	Reaction	Date/Year

INSECT ALLERGIES: Please list all that apply to the patient

Insect	Reaction	Date/Year

FOOD ALLERGIES: Please list all that apply to the patient

Food	Reaction	Date/Year

FAMILY HISTORY: Please mark all that apply

	Hay Fever	Sinus	Asthma	Eczema	Hives	Other (leave Blank
Father						
Mother						
__ Sisters __ Brothers						
Grandparents (Father's)						
Grandparents (Mother's)						
Children: __ Male #____; __ Female #____						

SOCIAL HISTORY: Please mark all that apply **Occupation**_____

Do you Smoke? __ Yes __ No How many packs-per-day _____, for how many years _____

Have you ever smoked in the past? __ Yes __ No How many packs-per-day _____, how many years _____

If you smoked in the past, when did you quit? _____ Other smokers in the home? ___Yes ___No

ENVIRONMENTAL SURVEY: Please check all that apply.

How long have you lived in Georgia? _____ Where else have you lived? _____

Your Home: __ Single Family Home __ Multiple Family Dwelling __ Apartment __ Mobile Home

The HOME	Age of House	How Long Living in Home	Heating System (type)	Type of Filter	Frequency of Filter Change	
	Air Conditioning __ Central __ Room	Attic Fan __ Yes __ No	Is Fan Used __ Yes __ No	Humidifiers __ Yes __ No	Areas of Dampness, Mold or Mildew __ Yes __ No Location _____	

PATIENT'S BEDROOM	Shared __ Yes __ No Carpeted __ Yes __ No	Bedding: __ Innerspring __ Waterbed	Age of Bedding _____ yrs. Allergy Covers __ Yes __ No	Comforter __ Down __ Synthetic.	Type of Pillows __ Down __ Synthetic	Age of Pillows _____ yrs. Allergy Covers __ Yes __ No

PETS: Do you have pets IN your home? __ Yes __ No

	How Many?	Allowed in Bedroom?	Describe any symptoms you have around the pet
Dogs		__ Yes __ No	
Cats		__ Yes __ No	
Birds		__ Yes __ No	
Other _____		__ Yes __ No	