Baz Allergy, Asthma & Sinus Center

Thank you for choosing our practice for your asthma and allergy needs. We are committed to the success of your treatment and care. We have fifteen offices to serve the needs of our patients.

We have scheduled your appointment in our _____office on ___/___/___at___:___am/pm
If you are unable to keep this appointment, please call to reschedule within 24 hours prior to the appointment.

- **FRESNO** 7471 N. Fresno Street, Fresno CA 93720 Phone: (559) 436-4500
- **S. FRESNO** 505 N. Clovis Ave, Fresno CA 93727 Phone: (559) 981-5040
- **NW FRESNO** 6643 N. Milburn Suite 101, Fresno, CA 93722 Phone: (559) 275-1400
- **N. CLOVIS** 2021 Herndon 2nd Floor Suite 201, Clovis CA 93611 Phone: (559) 472-3116
- **S. CLOVIS** 1420 Shaw Ave Suite 105, Clovis CA 93611 Phone: (559) 765-4665
- **HANFORD** 1560 W. Lacey Blvd., Suite 103, Hanford CA 93230 Phone: (559) 582-8500
- **VISALIA** 5410 W. Cypress Ave, Suite 102, Visalia CA 93277 Phone: (559) 713-1600
- **REEDLEY** 563 I Street, Reedley, CA 93654 Phone: (559) 637-2135
- **MADERA** 2311 W. Cleveland, Suite 1, Madera CA 93637 Phone: (559) 674-0075
- **MERCED** 139 W. El Portal Dr. Bldg 11, Suite D, Merced, CA 95348 Phone: (209) 354-4675
- **TURLOCK** 1199 Delbon Ave Suite 1, Turlock, CA 95382 Phone: (209) 656-1617
- **MODESTO** 1524 McHenry Ave Suite 470, Modesto, CA 95350 Phone: (209) 409-8454
- **LOS BANOS** 600 West I Street Suite B, Los Banos, CA 93635 Phone: (209) 710-8684
- **SAN LEANDRO** 13851 E. 14th Street Suite 205, San Leandro, CA 94578 Phone: (510) 969-5418
- **FREMONT** 1860 Mowry Suite 400, Fremont, CA 94538 Phone: (510) 894-0051

WHEN PAYMENT IS DUE :
Charges not covered by your insurance are due at the time of service this includes any **CO-PAYS**, **CO-INSURANCES** and **DEDUCTIBLES**. Co-payments will not be billed and must be paid at the time of service. **PAYMENT IS DUE WHEN SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.** We accept cash, checks, Visa, MasterCard and Debit cards. A service fee of $50.00 will be added on any returned checks.

YOUR INSURANCE COVERAGE :
We attempt to alleviate as much of the "insurance hassle" as possible for our patients and as a courtesy we will call your insurance company to verify your coverage benefits prior to your visit. We encourage you to call your insurance company and review your benefit coverage. The benefits quoted to us are not a guarantee of payment. After the claim is filed any non-covered services become the responsibility of the patient. If you have any questions regarding your financial responsibilities at our office, please do not hesitate to ask our billing department, prior to being seen or any procedures provided.

In order to save you time and avoid inconvenience, we anticipate allergy testing may be involved during this visit. Please be aware that your first visit may take up to two to three hours. If this appointment is not for a child we strongly suggest that children not accompany you. Allergy testing requires the patient to be perfectly still and we have found that patients with children are unable to do so. **DO NOT TAKE ANTIHISTAMINES 3-5 Days PRIOR TO YOUR VISIT.** Enclosed you will find a list of medications to avoid, if taken we will be unable to do any allergy testing. Asthma medication, as well as other medications may be continued. **Please bring all medications (or a complete list) you are currently taking to your appointment.**

MINOR PATIENTS: The parent or guardian accompanying a minor is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied.

To expedite your visit we have enclosed forms, which will need to be completed by you. Please bring the completed forms and your insurance card with you to your appointment. To help the doctor provide you with the best possible diagnosis of your condition the patient's history needs to be completed thoroughly.
If you have any questions regarding these instructions, or if you have any concerns, do not hesitate to call.

We look forward to seeing you, **BAZ ALLERGY, ASTHMA & SINUS CENTER**

ANTIHISTAMINES TO BE STOPPED FOR **POSSIBLE** ALLERGY TESTING:

Stop THREE days before testing:

Actagen
Actifed
Acrivastine
Allegra (any)
Allerclear
Allerfrin
Allertec
Allerx
Antivert
Benedryl
Bromphed
Brompheniramine
Cetirizine
Chlorpheniramine
Chlor-trimeton
Clarinex (any)
Claritin (any)
Clemastine
Cyropheptadine
Deconamine
Dimenhdrinate
Dimetane
Dimetapp
Diphenydramine
Doxepin
Dramamine
Drixoral
Duravent-DA
Fexofenadine
Histavent-LA
Histex
Loratadine
Meclizine
Ominihist-LA
Ornade
Pediacare
Periactin
Phenergan
Poly-histine
Promethazine
Rondec
Rynatan
Ryna-12
Rynatuss
Semprex-D
Tanafed
Tavist
Triaminic
Triaminicol
Trinalin
Tripolidine
Tussi-12
Tussionex
Vistaril
Wal-tin

NASAL SPRAYS:

Astelin
Astepro
Azelastine
Patanase
Dymista

EYE DROPS:

Pataday
Patanol
Olopatadine
Optivar
Zaditor
Pazeo

Stop FIVE days before testing:

Atarax
Hydroxyzine
Xyzal
Zyrtec

ALSO: Any medicine that has the words **SINUS, ALLERGY OR "HIST"**

Please advise the patients the following: Many over the counter medications have allergy medicine in them (i.e. **sinus, headache, sleep or cough medicines**). These medications will need to be stopped 4 days prior to the visit as well. If you are not sure if the medicine you are taking contains an antihistamine, please call the office for advice. **DO NOT** stop any other medications for heart, liver, lung or other conditions. If for some reason you cannot stop the allergy medications then don't. We will see you for the consultation and can reschedule for testing at any time.

(4/15)

Baz Allergy, Asthma & Sinus Center

DO NOT TAKE ANY ANTIHISTAMINES, IF POSSIBLE, FOR 72 HOURS BEFORE YOUR FIRST VISIT. CONTINUE THE REST OF YOUR MEDICATIONS

Name:	Age:	Sex:	Date:

Occupation/Job Description:	DOB:

Address:	Phone#:

Hobbies:

Family Doctor:	Who Referred You To Our Office:

Doctor's Seen In The Past:

Primary Reason For Seeing Us Today? ☐ Allergies ☐ Asthma ☐Sinusitis ☐Headaches ☐Cough ☐ Hives ☐Eczema

Other:

Please Check All That Trigger Or Make Your Allergies Worse

Previous Allergy Evaluation:

Have You Ever Seen An Allergist? Yes/No Name:_____

Have You Ever Had An Allergy Skin Testing? Yes/No

Have You Ever Received Allergy Injections/Drops? Yes/No
If YES, Were The Injections/Drops Helpful? Yes/No

Nose / Eyes: ☐All Year ☐ Seasonally

When Do You Have These Symptoms?

Check Symptoms		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	Runny Nose												
	Stuffy Nose												
	Sneezing												
	Post Nasal Drip												
	Itchy Eyes/Nose												

Allergens				Irritants			
	Freshly Mowed Grass		House Dust		Smoke		Outside Dirt
	Dead Grass		Cat		Perfumes		Fumes
	Hay		Dogs		Soaps		Windy Days
	Flowers		Feathers		Cosmetics		Cold Days
	Trees				Cleaning Product		Damp Days
	Tree Pollens				Paint Fumes		Alcoholic Beverages
	Weeds				Hair Spray		Spicy Food

Head: ☐ Headaches ☐ Facial/Sinus Pain

☐ Sinus X-ray Done? When: _____ Where: _____

Other Symptoms?

Ears: ☐Popping Of Ears ☐Ear Aches ☐ Ear Tubes

Other Symptoms:

DOCTOR'S USE ONLY
(PLEASE DO NOT WRITE IN THIS ARE)

Historian?
☐ Patient ☐ Other_____

How Long?
☐ Perennial ☐ Seasonal
☐ Spring ☐ Summer
☐ Fall ☐ Winter

Severity: ☐ Mild
☐ Moderate
☐ Severe

Frequency:_____x wk/month

☐ Nausea ☐ Vomiting
☐ Diplopia ☐ None

☐ Entered into IMS

☐ Scanned HX

Chest: ☐ALL YEAR ☐ SEASONAL

Do You Wheeze? Yes/No
- ☐ When You Get A Cold?
- ☐ When Exposed To Cold Air?
- ☐ At Night?
- ☐ When Exercising?

Do You Cough? Yes/No
- ☐ When Exposed To Cold Air?
- ☐ At Night?
- ☐ When Exercising?

Productive Cough? Yes/No

Color? ☐Clear ☐Yellow ☐ Green ☐ Brown

How Long Have You Had This Cough? _____

How Many Months Of The Year Do You Have This Productive Cough? _____

Check Symptoms	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wheezing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Chest X-rays Done? Yes/No When? _____ Where? _____

Have You Ever Been Diagnosed With Chronic Bronchitis? Yes/No

Have You Ever Been Diagnosed With Emphysema? Yes/No

Skin Problems: Yes/No

☐ Eczema How Long? _____

☐ Hives How Long? _____

Any Problems With Rubber Or Latex Material? Yes/No

Other Skin Diseases Or Symptoms?

Food Allergy/Stomach Problems:

☐Gas ☐ Cramps ☐ Diarrhea ☐Others? _____

Which Food(s) And What Kind Of Reactions Do You Have?

Insect Allergy:

Have You Ever Had An Allergic Reaction To An Insect Bite? Yes/No

If YES, Please Check All Insects That Have Triggered An Allergic Reaction

☐ Honey Bee ☐Yellow Jacket ☐White Faced Hornet

☐ Wasp ☐ Kissing Bug ☐Other Insects

Environmental	INSIDE	OUTSIDE	SLEEPS IN BEDROOM
Cats	☐	☐	☐
Dogs	☐	☐	☐
Other	☐	☐	☐

Past Medical/Surgical History:

Please List Illnesses/Surgeries You Have Had In The Past

DOCTOR'S USE ONLY

How Long?

☐ Perennial ☐ Seasonal

☐ Spring ☐ Summer

☐ Fall ☐ Winter

☐ Cough ☐ Wheezing

☐ Chest Tightness

Nocturnal Symptoms? Y / N

Frequency:_____x wk/month

Beta Agonist Use?

Frequency:_____x wk/month

Use in last _____ day(s) / wk(s)

Any Hospitalizations For Asthma? Y / N

If yes, when was the last time?

Medications:

List All Medications, Including Over The Counter Medicine, Birth Control, Vitamin Supplements, And Herbal Medicine.
Please Include Dosage And How Many Times A Day You Take It.

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Drug Allergies: Yes/No

If YES, Please List The Drug(s) And Type of Reaction.

Social History:

Do You Smoke? Yes/No If YES, For How Long? _____
How Much? _____
Have You Quit Smoking? Yes/No If YES, When? _____
Does Anybody Else Smoke In The House? Yes/No
Who? _____
Do You Drink Alcohol? Yes/No How Much? _____
Do You Use Any Other Recreational Drugs? Yes/No
Please List _____
Any Animals Or Smokers At Baby Sitters, Grandparents, Or Work? Yes/No
Please List

Birth History:

Please List Any Abnormal Conditions/Problems At Birth Or As An Infant:

Please Check All That Apply To You

Childhood History:

☐ Frequent Colds ☐ Frequent Bronchitis ☐ Excessive Fatigue

☐ Frequent Sinusitis ☐ Frequent Ear Infections

☐ Frequent Sore Throats ☐ Frequent Headaches

☐ Frequent Wheezing ☐ Frequent Coughing

Any other Conditions? (Please List)

Family History:

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Please Check If Any That Apply To Family Members

	Hay Fever	Asthma	Eczema	Sinus Problems	Other Allergies
Brother(s)	☐	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Maternal Gr. Parents	☐	☐	☐	☐	☐
Paternal Gr. Parents	☐	☐	☐	☐	☐

Please List Any Family Diseases:

Female Patients:

Are You Taking Birth Control Pills? Yes/No

Do You Have Regular Menses Cycles? Yes/No
If YES, When Was Your Last Menstruation? _____

Are You Pregnant? Yes/No

Housing:

Please Check If Any That Apply To You

	Feather Pillows		Humidifier		Swamp Cooler
	Feather Comforters		Dehumidifier		Wood Burning Stove
	Stuffed Toys		Hepa Filter System		Indoor Plants
	Carpeting		Central Air/Heating		Book Cases

Is There Anything Near Your Home That Might Pollute The Air Or Water? Yes/No

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Any Children? Yes/No If YES, How Many? _____
Please List Their Names:

Form Completed By Whom? _____ Relationship: _____

What Do You Expect From Your Allergist?

Baz Allergy, Asthma & Sinus Center

FINANCIAL POLICY

Our continued participation in your health plan depends upon everyone fulfilling his/her obligation in accordance with the contracts. As a service to our patients, we obtain a description of benefits from your Insurance. This office is not responsible for incorrect benefit information given to us by your insurance carrier, or changes in coverage after verification date. A description of benefits is not a guarantee of coverage and cannot be relied on as such. In the event of non-payment by your insurance company the charges on your account will be your responsibility. Patients are responsible for all deductibles, co-payments, coinsurance and non-covered charges. Payment is due at the time service is rendered. We accept Visa, MasterCard, Discover, Personal Checks and Cash for your convenience. If you want to verify the insurance benefits quoted yourself, please call your insurance company.

PATIENT CONSENT: I hereby give consent for such medical treatment for myself or I am duly authorized by the patient and his/her general agent to consent for such treatment.

ASSIGNMENT OF BENEFITS: I hereby authorize payment for medical benefits directly to the provider of the services rendered.

RELEASE OF INFORMATION: I hereby authorize the release of any medical information necessary to process any insurance claims.

Patient Signature:_____**Date:**_____

Patient Name: Account Number:

MEDICAL INFORMATION RELEASE

This is to advise you that I have given authorization to Baz Allergy, Asthma & Sinus Center to provide any and all necessary information regarding my medical care to the following individuals below. This authorization is effective until terminated in writing.

Name (print) Relationship to Patient

Name (print) Relationship to Patient

Name (print) Relationship to Patient

Signature of Patient (If under 18 need parent/guardian signature) Date

EMERGENCY PHONE NUMBERS

Name (print) Work Home Cell Relationship to Patient

Name (print) Work Home Cell Relationship to Patient

Name (print) Work Home Cell Relationship to Patient

Signature of Patient (If under 18 years need parent/guardian signature) Date

Baz Allergy, Asthma & Sinus Center

NOTICE OF PRIVACY PRACTICES

Privacy Officer (559) 436-4500

Effective Date: September 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU AND GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may

also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign-in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the face and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to

communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a 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. If you tell us not to disclose information to your commercial health plan concerning healthcare items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or

which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.
   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 our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019; (800) 537-7697 (TDD)
OCRMail@hhs.gov

The complaint form may be found at www.hhs/gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf
You will not be penalized in any way for filing a complaint.

Baz Allergy, Asthma & Sinus Center

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

[ ] I would like to receive a copy of any amended Notice of Privacy Practices by email at:

_____

Signed: _____Date:_____

Print Name: _____Telephone: _____

If not signed by the patient, please indicate relationship:

Parent or Guardian of minor patient

Guardian or conservator of an adult patient

Name and Address of Patient: _____

_____

_____

PATIENT DEMOGRAPHICS 2016

Please print clearly and complete entire form.

First Name _____**M.I.** _____**Last Name**_____

Date of Birth _____ **E-Mail** _____

Address _____**City** _____ **State** _____**Zip**_____

Home Phone _____**Cell phone** _____

Pharmacy (include cross-streets)_____

Race:
- ☐ American Indian or Native of Alaska
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White/Caucasian
- ☐ Unreported/ Refused

Ethnicity:
- ☐ Hispanic or Latino
- ☐ NOT Hispanic or Latino
- ☐ Refused

Patient Signature _____ **Date** _____

Baz Allergy, Asthma & Sinus Center

Insurance Benefits

As a courtesy, we have verified your Insurance coverage and benefit information with your Insurance company.

Baz Allergy, Asthma & Sinus Center is not responsible if incorrect benefit information is given to us by your insurance carrier, or any changes in coverage after the date of verification. **It is ultimately your responsibility to know your benefits and coverage. It is recommended you call your insurance company to verify any benefits quoted.**
In the event of non-payment by your insurance company any accrued charges are your responsibility.

Patient Name: _____
(Please print)

Patient Signature: _____ Date: _____
(If patient is under 18 parent or guardian must sign)