

Date: _____

ACCT# _____

Patient's Name:		Marital Status: (Circle) S M W DIV SEP			Sex: (Circle) F M		Date of Birth:	Age:
Street Address: ___ Perm ___ Temp <small>(No P.O. Box)</small>		City / State:			Zip Code:		Home Phone:	
Occupation of Patient:		Patient's Employer:			How Long Employed:		Cell Phone:	
Employer's Street Address:		City / State:			Zip Code:		Business Phone:	
Primary Language Spoken:	Email Address:			Driver's License No.:		Social Security No.:		
How did you first find out about the practice?		Primary Care Physician:			Referring Physician's full name:			

Spouse's Name:		Spouse's Employer:			How Long Employed:		Occupation of Spouse:	
Employer's Street Address:		City / State:			Zip Code:		Business Phone:	

IF THE PATIENT IS A MINOR OR STUDENT / EMERGENCY CONTACT

Mother's Name:		Street Address:		City/State:	Zip Code:	Home Phone:		
Mother's Employer:		Occupation:			How Long Employed:		Cell Phone:	
Employer's Street Address:		City/State:			Zip Code:	Business Phone:		
Social Security #:		Date of Birth:			Driver's License #:			
Father's Name:		Street Address:		City/State:	Zip Code:	Home Phone:		
Father's Employer:		Occupation:			How Long Employed:		Cell Phone:	
Employer's Street Address:		City/State:			Zip Code:	Business Phone:		
Social Security #:		Date of Birth:			Driver's License #:			

INSURANCE INFORMATION

Insurance Company:		
Type of Coverage: ___ PPO ___ POS ___ HMO ___ Medicare/Medicaid ___ W/C ___ Self Pay ___ EPO ___ Indemnity		
Insured Policy Holder Name:		Insured Policy Holder Date of Birth:
Insured Policy Holder Social Security #:		

PHYSICIANS RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Florida Center for Allergy and Asthma Care of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim or as required by law. I request payment of medical insurance benefits either to myself or to Florida Center for Allergy and Asthma Care who accepts assignment. **I understand that I am financially responsible for charges regardless of coverage. All deductibles, co-payments, co-insurance's, and other balances are paid at the time services are rendered.**

Patient's/Guarantor's Signature:	Date:
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For office use only.

K WK CG PB KRH HL B AV HW WT PP PL CS F BR // P JL ZL FR RY PM FM E IR CA LL CO KS

Florida Center For Allergy & Asthma Care

Administrative Office

11880 SW 40 ST., SUITE 304
Miami, Florida 33175

Phone: 305-223-8808 / Fax: 305-223-8974
info@florida-allergy.com
www.florida-allergy.com

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Charlene Shookoff, M.D.
Jose Carpio, M.D.
Sharlene Llanes, M.D.*
Martin R. Correa, M.D.
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April 10, 2006

Dear patient,

HIPAA (Health Insurance Portability and Accountability Act) Regulations require us to provide a notice to our patients about our privacy practices, our legal duties and their rights concerning their health information. We also, are required to attempt to obtain a written acknowledgement of receipt of our Notice of Privacy Practices.

I am enclosing our Privacy Notice and an acknowledgement form. Please read the notice, complete the acknowledgement and return it to the office in which you are being treated.

If you have any questions concerning our Privacy Notice, please call the office which you are being treated. The staff will direct you to the appropriate employee for additional information.

Sincerely,



Sharon Peña
Chief Operating Officer

Homestead
Weston

Kendall
Pembroke Pines

West Kendall
Hollywood

Coral Gables
Plantation

Hialeah
Fort Lauderdale

Miami Beach
Coral Springs

Aventura
Boca Raton

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH IS IMPORTANT TO FLORIDA CENTER FOR ALLERGY AND ASTHMA CARE (FCAAC).

THIS NOTICE COVERS THE FOLLOWING ENTITIES PROVIDING YOUR CARE:

All employees, physicians, physician assistants, nurse practitioners, nurses, administrative staff and any other health care professionals providing you care through FCAAC must abide by this Notice of Privacy Practices. FCAAC may share your information with these covered entities to help them provide medical care to you.

PART 1 – FCAAC’S LEGAL DUTY

FCAAC is required by applicable federal and state law to maintain the privacy of your health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Your health information is anything we have created or received regarding your health or payment for your healthcare. It includes both your medical records and personal information such as your name, social security, address and phone number. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PART 2- HOW WE MAY USE AND DISCLOSURE HEALTHCARE INFORMATION ABOUT YOU

We use and disclose health information about you for treatment, payment and healthcare operations; for example:

Treatment. We may use or disclose your health information to a physician, nurse, or other healthcare professional providing treatment to you. We may also use or disclose medical information to contact you by phone or mail to remind you of treatment or to inform you of test results.

Payment. We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

Homestead
Weston

Kendall
Pembroke Pines

West Kendall
Hollywood

Coral Gables
Plantation

Hialeah
Fort Lauderdale

Miami Beach
Coral Springs

Aventura
Boca Raton

Notice of Privacy Practices

To Your Family and Friends. We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services. We will not use your health information for marketing communications without your written authorization.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PART 3 - PATIENT RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page and \$10.00 per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee to provide your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

PART 4 – HOW YOU MAY ASK FOR HELP OR COMPLAIN

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer for FCAAC at the contact information below:

<p><u>Privacy Officers</u></p> <p>Geidy Rodriguez, Director of Office Operations Shannon Saunders, Director of Office Operations 11880 SW 40 Street, Suite 304 Miami, FL 33175 (305) 223-8808 grodriguez@florida-allergy.com</p>	<p><u>Office for Civil Rights</u></p> <p>U.S. Department of Health and Human Services 200 Independence Avenue, SW, HHH Building, Room 509H Washington D.C., 20201 Phone: 866-627-7748 TTY: 886-788-4989 Online: www.hhs.gov/ocr</p>
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
&
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT:

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Privacy Officers

Geidy Rodriguez, Director of Office Operations
Shannon Saunders, Director of Office Operations
11880 SW 40th Street
Suite 304
Miami, FL 33175
305-223-8808

Right to Revoke. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and have received a copy of your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

FOR OFFICE USE ONLY

<input type="checkbox"/> Individual refused to sign	<input type="checkbox"/> Communication barriers prohibited obtaining the acknowledgment
<input type="checkbox"/> An emergency situation prevented us from obtaining acknowledgement	<input type="checkbox"/> Other



PATIENT QUESTIONNAIRE

We are vitally interested in the development of new medications for the treatment of allergic diseases. We are involved in many research studies with various pharmaceutical companies who are ready to introduce new treatments for allergic diseases. Some studies offer patient compensation for time and travel. If you are interested in taking part in one of our future medication trials, please fill out this form.

Date: _____ Name: _____

Parent/Guardian Name (if under 18): _____

Birth Date: _____ Sex: M/F Ethnic Background: _____

Address: _____

City: _____ State: _____ E-mail Address: _____

Phone (home):(____) _____ (work):(____) _____ Zip: _____

Do you have asthma? _____ When did it begin? _____ Do you have allergies? _____

What type of allergies? _____

Do you have: Sinusitis? _____ How often? _____ Do you have or get hives? _____

Other medical conditions? _____

Do you smoke? _____ Were you ever a smoker? _____ If "yes", when did you quit? _____

How long did you smoke? _____ Are you allergic to Aspirin or other pain relievers? _____

List any other medications you are allergic to: _____

Are you on allergy shots? _____ How long? _____

May we call you when your profile fits a particular study criteria to determine if you are interested in that trial?

Thank you for taking the time to complete this questionnaire. ☺

Florida Center

For Allergy & Asthma Care

How did you first find out about Florida Center For Allergy & Asthma Care?

Please fill out lines 1 and 2 and **check ONE** of the appropriate box categories that best describe how you first heard of one of our specialists or our practice. Your help is greatly appreciated.

1. **What is the name of your primary care physician?** _____
2. **Did you require a referral authorization to be seen at our practice?** [] YES [] NO

Referred by:

- [] Primary Care Physician
- [] Other physician: Name: _____
- [] Family member or friend

Insurance Provider Directory:

- [] HMO [] PPO [] POS [] Indemnity [] Other _____

Media:

- [] Television commercial
- [] Television news story
- [] Newspaper article
- [] Magazine Article

Internet

(If you saw us on the Internet, on which web site did you see Florida Center For Allergy & Asthma Care or our physician on?)

- [] www.Florida-Allergy.com
- [] Miami.com or Herald.com
- [] *Real Yellow Pages on-line*
- [] *American College of Allergy Asthma & Immunology (www.aaaai.com)*
- [] *American Academy of Allergy Asthma & Immunology (www.aaaai.com)*
- [] *Online Hospital Directory*

Print Advertisement (Please circle which publication you had seen our advertisement)

- [] *Miami Herald* [] *Sun Sentinel*
- [] *Dade Community Paper* [] *Bell South Real Yellow Pages*
- [] *Broward Community Paper*

[] Public Fair, Show or Exhibition

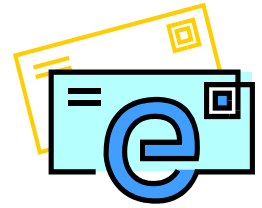
If you recall, what is the name of the event? : _____

[] Other: _____

Thank you for taking the time to complete this valuable survey 😊
Please return this form to the Front Desk Staff.

Florida Center

For Allergy & Asthma Care



Email Updates

The physicians and staff at Florida Center For Allergy & Asthma Care would like the opportunity to provide you with the latest information, news and messages that can benefit your treatment. In order to better serve you and contact you more efficiently, we ask that you provide us with your email address. **Please note that the use of your email is intended only for use by Florida Center For Allergy & Asthma Care.**

First Name / Last Name

Date of Birth

Your email address

THANK YOU FOR YOUR ASSISTANCE

This area intended for office use only

Patient Account #

Office Mng. initial here