Allergy, Asthma & Immunology Center, P.C.

Vital Prospects Clinical Research Institute, P.C.

Iftikhar Hussain, MD

Registration Form & Policies (Please Print Legibly)

Preferred Pharmacy: _____ **Address:** _____ **Phone:** _____

Name (last, First, MI): _____ DOB: _____

Social Security #: _____ PCP: _____ Referring Provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Gender: Male Female

Employer: _____ Occupation: _____

Marital Status: Single Married Widowed Divorced Other _____

Ethnicity: Non-Hispanic Hispanic or Latino Refuse to report Other _____

Race: White Black Or African American Hispanic American Indian Asian Other _____

Primary Insurance Information

Primary Insurance: _____ Member/Policy Number: _____

Group Name/Number: _____ Policy Holder Relationship: _____

Policy Holder: _____ DOB: _____ Social Security #: _____

Phone: _____ Holder's Employer and Phone: _____

Secondary Insurance Information

Secondary Insurance: _____ Member/Policy Number: _____

Group Name/Number: _____ Policy Holder Relationship: _____

Policy Holder: _____ DOB: _____ Social Security #: _____

Phone: _____ Holder's Employer and Phone: _____

IF A MINOR, PLEASE COMPLETE BELOW: Parent, legal or custodial guardian **(where the child lives)**

Relationship: _____ Name: _____ DOB: _____

Soc Sec #: _____ Email: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Signature

PRINTED name of person completing this form

Patient (Parent/Guardian) Signature

Relationship to patient

Date

Allergy, Asthma & Immunology Center, P.C.

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HIPAA Right of Access Form for Family Member/Friend

Please list below any person(s) to whom we may inquire and/or inform about your general medical information, conditions or diagnosis. (These will be listed as Emergency Contacts)

Name: _____ Relationship: _____ Cell: _____

Information to be released to above (please initial ONE)

_____ Complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment & billing)

_____ Complete health record as above, EXCEPT mental health, communicable diseases, alcohol/drug abuse treatment

Name: _____ Relationship: _____ Cell: _____

Information to be released to above (please check)

_____ Complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment & billing)

_____ Complete health record as above, EXCEPT mental health, communicable diseases, alcohol/drug abuse treatment

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AFTER REVIEWING EACH SECTION BELOW, PLEASE INITIAL.

_____ (Initial) **AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION:**

I authorize AAIC to release my medical information and/or individually identifiable health information to me(us) or my(our) duly authorized representative (as noted above), representatives of local, state, or federal agencies and insurance companies or other organizations or entities as may be required to be permitted under federal or state law or for review or payment of claims. I further authorize AAIC to release such information to physicians, hospitals or healthcare providers in order to treat me or to review my treatment. I understand that the specific information to be released may include, but is not limited to, history, diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I also understand I may revoke this authorization with a written and dated notice except to the extent that disclosure of information has been made prior of receipt of revocation.

_____ (Initial) **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONDITIONS OF TREATMENT**

The notice of Privacy practices provides specific information and complete description of how my personal health information may be used and disclosed. I(we) acknowledge that upon my request I(we) have been provided and have reviewed the Notice of Privacy Practices (dated June 1, 2018) and Conditions of Treatment. I(we) understand that as part of my healthcare, AAIC maintains health records describing my health symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand this information is used to plan my care and treatment and to bill for services provided. It is also used to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals as required or permitted by law without my consent.

_____ (Initial) **AUTHORIZATION TO CONTACT PATIENT OR ACCOUNT REPRESENTATIVE:** I (we) hereby authorize AAIC physicians and staff to leave detailed information by mail, phone, text or email regarding lab results, clinical information and account balance(s).

PRINTED name of person completing form _____ **Patient (Parent/Guardian) Signature** _____

Relationship to patient _____ **Date** _____

7307 S. Yale Ave., Ste. 200 * Tulsa, Oklahoma 74136-8303 * Phone (918) 392-4550 * Fax (918) 392-4551

Allergy, Asthma & Immunology Center, P.C.
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2024 FINANCIAL POLICY

Patient Name: _____

Allergy, Asthma & Immunology Center, P.C. is extremely pleased to provide care to you and your family. The following outlines our clinic's financial policy for 2024.

We must emphasize that as a medical practice, our relationship is between you and AAIC providers, not the insurance company. While filing insurance claims is a courtesy that we extend to our patients, it is ultimately your responsibility to understand your policy benefits. AAIC contracts with most major insurance companies. **It is your responsibility to verify AAIC is in network with your insurance carrier.** ***Patients are responsible for any portion of charges deemed non-covered or noted as "patient responsibility."*** Services listed as "covered" by your plan are still subject to the patient financial liability for deductibles, co-insurance, and co-payments (as outlined per your plan).

AAIC is an independent private practice clinic and strongly recommends that patients check in advance 1) insurance benefits and exclusions and 2) financial responsibilities they may have with non-AAIC entities such as outside labs, clinics, pharmacies, or other physicians.

Once the record of insurance has been established it will be your responsibility to notify us of any changes. If you do not, you will be fully responsible for any amount rejected by insurance. **If you have no insurance or a high deductible plan, a $250 down payment is expected at time of service for new patients; $200 is expected at time of service for established patients.** The business office is available to assist with a formal payment plan for any remaining balance.

All co-payments are due at the time of service, including patients who have a co-pay and/or co-insurance associated with administering injections. If your insurance provider requires a referral, such as Tricare Prime, VA, Sooner Care, or Generations Global Health, **you** are responsible for obtaining a referral to our office from your primary care physician. **This must be received by AAIC no later than 48 hours prior to the appointment. We follow guidelines set forth by these plans and services cannot be rendered if not authorized. Referrals should be faxed to 918- 392-4551.**

Once your claim has been processed you will receive a statement of patient responsibility for the services provided. Payment in full is expected upon receipt of statement(s). AAIC accepts payment by cash (in office only), check or credit card including Amex®/ Care Credit/ Discover®/ MasterCard®/Visa®.

Payments can be taken by phone (918) 392-4550 or mailed to:

AAIC
7307 S. Yale Ave., Ste 200
Tulsa OK 74136-8303

If your insurance company does not respond within 30 days after your claim is filed, payment will become your responsibility. Any amount remaining after insurance has been paid or denied will be expected to be paid upon receipt of your statement unless other arrangements are made with our billing department. If you are unable to pay your balance in full upon receipt of your statement, please call to speak with our billing staff to set up a monthly payment plan.

Allergy, Asthma & Immunology Center, P.C.
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2024 FINANCIAL POLICY
(Continued)

Patient Name: _____

*Patients with unpaid delinquent balances after 90 days will be sent to a collection agency and patient is responsible for up to 7**0% collection agency fees** in addition to the account balance. **All unpaid balances are subject to the Small Claims Court**. Satisfactory payment arrangements or account balance settlement are required before receiving any future services.*

A $50 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pay cash, money order or credit card for services.

Please be considerate of other patients when canceling or rescheduling an appointment. A no show fee of $50 for an office visit and $100 for an Infusion or 2 hour appointment could be charged if not cancelled or rescheduled at least 24 hours in advance. For your convenience you can notify us by calling (918) 392-4550.

We are committed to providing our patients with quality care. By informing you of our expectations, we hope to alleviate any misunderstandings concerning your financial responsibility. Should you have questions about your account, please contact our office at (918) 392-4550 and ask for the billing department.

I authorize release of any information necessary to process claims and direct payments to Allergy, Asthma & Immunology Center, P.C. I understand that I am responsible for all charges, regardless of insurance coverage. If the patient is a minor, the financial responsibility lies with the parent or guardian bringing the child for treatment.

I understand and agree to the terms of this financial policy.

_____ _____
Signature of patient or responsible party Relationship to patient

Date: _____

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Allergy, Asthma & Immunology Center, P.C.
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GENERAL DISCLOSURE AND INFORMED CONSENT FOR MEDICAL & DIAGNOSTIC PROCEDURES

TO THE PATIENT: You have the right, as a patient, parent, or legal guardian, to be informed about the condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether to undergo the procedure after knowing the risks and hazards involved. This is simply an effort to make you better informed so you may give or withhold your consent to the procedures recommended to you.

I am of sound mental and physical condition and can give informed consent. I acknowledge that I am fully aware of the care, treatment, and/or services that I am going to receive that is subject of this form. I consent to Allergy, Asthma and Immunology providers and support staff to treat my conditions involving any organ system of the body, but primarily nasal allergy, eye allergies, asthma, eczema, urticaria, angioedema, headaches, and gastrointestinal symptoms.

I understand that the following medical and/or diagnostic procedures may be necessary for me and I voluntarily consent and authorize these procedures as deemed necessary upon examination:

1) Skin testing (Percutaneous and Intradermal)
2) Patch tests
3) Immunotherapy
4) Spirometry
5) Blood or Imaging studies (X-rays)
6) Oral challenges or desensitization
7) Rhinoscopy
8) Punch Biopsy
9) Topical anesthetics (Lidocaine and Epi)
10) Injections (steroid or biologic medications)
11) Nebulized medications
12) Anaphylactic measures

I understand that my physician may discover different conditions which may require additional procedures than those planned. I realize that common to medical and/or diagnostic procedures is the potential for infection, hemorrhage, syncope, allergic reactions and in very rare instances, even death due to severe systemic reaction. I authorize my physician and such associates, technical assistants and other health care providers to perform such other procedures, that are advisable in their professional judgment which might include escalation of care including calling paramedics. I understand that no warranty or guarantee has been made to me as to the result of any procedure or cure of any condition. Just as there may be risks and hazards in continuing my present condition with or without treatment or procedure(s), there are also risks and hazards related to the performance of the medical and/or diagnostic procedures which may be planned for me.

For example:
For patients that start immunotherapy (**allergy injections**): I understand that immunotherapy may result in complications of anaphylaxis and even death. The American Academy of Allergy, Asthma and Immunology recommends that immunotherapy be given under a physician's supervision. This practice believes this position is medically appropriate and that you should always obtain your injection by trained personnel, either in our office or another medical setting. Thus, I understand that the immunotherapy is to be administered under a physician's supervision. Furthermore, I understand that it is required for me to wait **AT LEAST 20-30 MINUTES** after each allergy injection before leaving the physician's office. If I leave early, I understand that it is against medical advice and will hold my treating physician and staff at AAIC free of any liability.

I have received sufficient information to give this informed general consent to treat. I acknowledge that this disclosure and informed consent has been fully explained to me, that I have read it or have had it read to me and that I understand its contents.

Patient Name: _____

Patient Signature: _____ Date: _____

Name of legal guardian (if minor): _____

Signature of legal guardian: _____ Date: _____

Allergy, Asthma & Immunology Center, P.C.
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2024 No-Show and Co-Pay Policy

Patient Name: _____

All office visit and shot co-pays will be due at the time of the service.

Please be considerate of other patients when canceling or rescheduling an appointment. Any appointment not cancelled or rescheduled at least 24 hours in advance could be charged a **$50 No-Show Fee**. This fee must be paid in full immediately.

The No-Show Fee is the responsibility of the patient. No insurance will pay for this fee.

I understand and agree to the terms of this financial policy.

_____
Signature of patient or responsible party

_____
Relationship to patient

_____
Date

Allergy, Asthma & Immunology Center, P.C.
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Name: _____ Age: _____ Date: _____

Chief Complaint:

_____

Please list adverse reactions to any drugs, foods, or insect stings:

_____

_____

Current Medications:

Medication	Dose	Frequency	Indication	Start Date	Stop Date

Medical History (Diagnosis):

_____

_____

Surgical History (Procedure):

_____

_____

Any Communicable Diseases? **Yes** **No** If Yes: Circle of list below:

HIV AIDS HEP C Other: _____

Family Health History: Place an "X" for or next to your response

Family Member	Allergy/Sinus	Eczema	Asthma	Heart Disease	Unknown
Mother					
Father					
Sister /Brother					
Grandmother/Father					
Aunt/Uncle					

Reviewed by: _____ Patient DOB: _____

Allergy, Asthma & Immunology Center, P.C.
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Name: _____

Social History:(Please Circle)

Smoker? Yes No **If Yes:** How many per day? _____

Date started? _____ Date stopped? _____

Alcohol Consumption? Yes No Caffeine Intake? Yes No

Recreational Drug? Yes No Exercise? Yes No

Home Smoke Detector? Yes No Humidifier in home? Yes No

Type of residence? House Condo Apartment Trailer

What is the age of your home? _____

Type of flooring at home? Carpet Wood Area Rugs

Any pets at home with fur or feathers? Yes No

If yes: What kind? _____

How Many? _____

Travel outside the United States? Yes No **If Yes: Where?** _____

Sexually Active? Yes No

Review of Symptoms (Please circle)

Allergy	**General**	**ENT**	**Respiratory**
Runny Nose	Weight Gain	Cold	Chest Pain
Scratchy Throat	Weight Loss	Cough	Cough
Itchy Eyes	Weakness	Nose Bleeds	Wheezing
Sneezing	Loss of Appetite	Hearing Loss	Shortness of Breath
Ear Fullness	Fatigue	Change in Voice	Chest Congestion
Sinus Congestion	Fever	Sore Throat	Dyspnea
Sinus Drainage	Breastfeeding	Ringing in Ears	Sleep Disturbance
Itchy Nose	Formula Feeding	Sinus Pain/Headaches	Difficult to breath lying down

Reviewed by: _____ Patient DOB: _____

Allergy, Asthma & Immunology Center, P.C.
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Name: _____

Ophthalmology
Eye Irritation
Redness
Dryness
Eye Drainage
Blurred Vision
Diminished Vision
Loss of Vision
Seasonal Eye Sx

Endocrinology
Fatigue
Excessive Thirst
Weight Loss
Sleep Disturbance
Cold Intolerance
Heat Intolerance
Diabetes
Thyroid Disorder

Cardiology
Dizziness
Chest Pain
Palpitations
Rapid Heart Rate
High Blood Pressure
Low Blood Pressure
Leg Edema
Leg Pain

Gastroenterology
Nausea
Heartburn
Hemorrhoids
Vomiting
Blood in Stool
Diarrhea
Abdominal Pain
Constipation

Urology
Recurring UTI
Blood in Urine
Difficult Urinating
Frequent Urination
Nocturia

Dermatology
Eczema
Rash
Mole
Lumps
Hives
Skin Cancer
Acne

Neurology
Headache
Seizures
Insomnia
Memory Loss
Memory Changes
Tingling/Numbness
Dizziness

Hematology
Loss of Appetite
Varicose Veins
Swollen Glands
Easy Bruising
Other:

Musculoskeletal
Joint Stiffness
Leg Cramps
Joint Pain
Joint Swelling
Sciatica
Fracture
Carpal Tunnel
Osteoporosis Treatment

Psychology
Depression
Anxiety
High Stress
Sleep Disturbance
Suicidal Thoughts
Abuse
Eating Disorder
Agitation/Irritability

Reviewed by: _____ Patient DOB: _____