Allergy & Asthma Group
A Medical Corporation

Anlin Xu, M.D.
Katharine S. Nelson, M.D.
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June Y. Zhang, M.D.

2211 Moorpark Ave, Suite 130
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Phone (408) 358-1771

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Mountain View, CA 94040
Phone (650) 966-8201

100 Arch Street, Suite 2
Redwood City, CA 94062
Phone (650) 362-4643
www.sballergy.com

NEW PATIENT REGISTRATION

Date: _____

Patient's Name: _____
First **MI** **Last Name**

Sex: ☐ **Male** ☐ **Female** ☐ **Other** **Date of Birth:**_____

Street Address: _____ **City:** _____

State/Zip Code: _____ **Home Phone:**_____

Work Phone: _____ **Cell Phone:** _____

Email Address: _____ **Workers compensation?** ☐ **Yes** ☐ **No**

Pharmacy Name/Address: _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance: _____ **ID Number:** _____ **Group Number:** _____

Insurance is through: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** **Name and DOB of Subscriber:** _____

Secondary Insurance: _____ **ID Number:** _____ **Group Number:** _____

Insurance is through: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** **Name and DOB of Subscriber:** _____

If patient is a minor, are parents: ☐ **Married** ☐ **Divorced** **Custodial Parent:** _____

Custodial Parent's Home Phone: _____ **Work Phone:** _____

Date of Birth: _____

PHYSICIAN INFORMATION

Referring Physician: _____ **City:** _____

Primary Care Physician: _____ **City:** _____

Release Medical Records to Referring Physician: ☐ **Yes** ☐ **No** **Primary Care Physician:** ☐ **Yes** ☐ **No**

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: _____

Phone: _____ **Relationship to Patient:** _____

I, the responsible party, certify that the above information is true and correct to the best of my knowledge.

_____ _____ _____ _____
Signature of Patient, Parent or Legal Guardian **Print Patient's Name** **Relationship to Patient** **Date**

South Bay Allergy & Asthma Group
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Billing and Financial Policy

The following sets forth the policies of South Bay Allergy & Asthma Group, Inc. Please review this information and sign where indicated below:
I understand that it is my responsibility to furnish South Bay Allergy & Asthma Group, Inc. with current accurate insurance information, valid and updated insurance card, prior to an office visit and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered. If I fail to notify the office of a change in my insurance coverage, and claims are filed with incorrect insurance, I will be responsible for these charges.

It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted in-network provider prior to an office visit. South Bay Allergy & Asthma Group, Inc. and/or its representatives will make every effort to assist you but South Bay Allergy & Asthma Group, Inc. will not be held accountable for understanding every insurance plan. If the physicians of SBAAG are not under contract with my insurance carrier, I understand that it is my responsibility to pay for that portion of services not covered by the plan policy. Please see www.sballergy.com under "Patient Information" tab for instructions on how to check in-network status.

We are not Medi-Cal providers. We are unable to bill patients directly for medical care services; therefore, we will be unable to provide for your medical care if you have Medi-Cal insurance in most cases.
I understand that copayments are due at the time of service. I will be billed for any amounts due by me (co-payments / co-insurance / deductibles) and I have a financial responsibility to pay these amounts. All services not covered or approved by the insurance carrier remain my responsibility. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as "Final Notice" and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with these collection efforts.

I understand that the practice will attempt to obtain the necessary authorizations prior to services being rendered. I further understand that prior authorization is not a guarantee for payment and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges. I understand that if my insurance coverage is an HMO, EPO, or Managed Care type, that my insurance will only pay for services if prior authorization has been obtained for each visit. If I choose to be seen by the physician without the necessary authorization, I understand that I will be responsible for 100% of the charges.

I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party.

I also understand that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to South Bay Allergy & Asthma Group, Inc. immediately upon receipt.
I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged at $25.00 NSF fee. These amounts must be cleared with our financial office prior to your next appointment.

Charges for Services

Actual costs of services are based on information discussed during the office visit, the severity of the condition, and the length of time spent by the physician, and other factors, thus an actual cost cannot be quoted. ***The patient's responsibility for out-of-pocket costs is based on the contractual allowances per your insurance company and are not determined by SBAAG. Even if testing is covered by your insurance, you may be responsible for the cost if your deductible has not yet been fulfilled.***

Please call our office for the estimated pricing. Fee schedules are subject to change without any notice.

I hereby authorize South Bay Allergy & Asthma Group, Inc. to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering the services for the purpose of satisfying charges billed.

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

Appointment and Office Policies

We require a 24-hour cancellation notice, I understand that a cancellation fee of $50.00 may be billed directly to me. All cancellation fees must be cleared with our billing office prior to your next appointment.
I understand that if the physician requires additional time to complete any forms related to my care, there is a $25.00 fee associated with that service. I understand that I must have been seen within the past 12 months for any paperwork to be completed. Physician may waive fee if completed during an office visit.
I understand that to receive prescription refills, including immunotherapy prescriptions, I must be seen for an office visit by the physician once yearly.
I acknowledge that if I am 15 minutes or more late to an appointment, my appointment will be rescheduled per the South Bay Allergy late policy.
I understand that if I do not show to 2 or more appointments without 24 hour notice given, I may be dismissed from the practice.
I understand that the practice reserves the right to dismiss patients who are abusive to staff or providers.

_____	_____	_____
Signature of Patient, Parent, or Legal Guardian	Relationship to patient	Date

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Consent Form For Skin Test And Oral Challenge

If you or your child has a clinical history suggesting allergy, we may do skin testing or perform an oral challenge to confirm or rule out an allergic process. Allergy skin testing by scratch or intradermal technique is usually done for certain "immediate" allergic conditions such as nasal allergies, asthma, other respiratory tract conditions, hives, skin swelling, or anaphylaxis.

What is a skin test?

A skin test is a simple method for detecting common allergens in patients suspected of having an allergy.

- Small amounts of allergens are applied to the skin with a disposable plastic prong (a scratch test)
- Or, small amounts of suspected allergens are injected a few cells deep into the skin (intradermal test).
- If an allergy is present, a wheal (a swollen reddened area) forms within about 15-20 minutes, which is observed and graded by the nurse or physician.

Patients should not take antihistamines for at least 2-7 days before the testing, depending on the drug. Otherwise the skin test may be masked by the antihistamine. Patients usually are tested for a panel of suspected allergens considered by the doctor to be appropriate for their needs. Skin testing is charged per number of tests performed, it is up to the patient and physician to decide on the number of skin tests that will be performed.

What is an oral challenge?

Oral challenge is a procedure where small doses of a drug or food are given orally to find out if a person is allergic to it. Oral challenge is used when:

- A previous reaction to a drug or food is uncertain
- Skin testing cannot be performed because of the nature of the antigen e.g., some drugs do not react on conventional skin testing
- The risk of taking the drug in incremental doses is small compared to the benefits of finding out what is causing the problem

During an oral challenge, we administer a dose of a drug or food below that which would potentially cause a serious reaction. If there is no reaction, we then proceed with incremental increases to full therapeutic dose. Although there is always the possibility of severe reactions, the risk of an oral challenge is low and most reactions are mild.

Can Reactions Occur?

In general, reactions are infrequent and may present as local itching or swelling to skin testing sites, or mouth itching and hives during an oral challenge. It is rare, but serious even life threatening reactions may occur. In that case, the patient must inform the doctor immediately if they have left the office or proceed to the emergency room.

I understand fully the above explanation and give South Bay Allergy and Asthma Group, Inc. staff permission to proceed with skin testing/oral challenge on _____ myself or (check for self or for minor child)

_____ my child _____, DOB: ____/____/_____

(Print Childs Last Name, First Name) (mm/ dd / yyyy)

Signature: _____ Date: _____

(Signature of Patient or if minor of Parent/Legal Guardian)

Print Name: _____ Relation to Patient: _____

(Name of Patient or if minor of Parent/Legal Guardian)

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Advanced Beneficiary Notice of Non-Coverage

Telemedicine & Communications Consent

You have chosen to receive care through the use of telemedicine. Telemedicine enables healthcare providers at different locations to provide safe, effective, and convenient care through the use of technology. As with any health care service, there are risks associated with the use of telemedicine, including equipment failure, poor image resolution, and information security issues. Doxy.me is a HIPAA compliant platform and all data is encrypted, your sessions are anonymous, and none of your information is stored.

This visit will be billed to your insurance; it may be applied to your annual deductible and rarely insurance may not be covered. If your insurance company does not cover Telemedicine, you will be responsible for payment of $100.

I understand the risk and benefits of telemedicine as explained? Yes____ No____

Do you consent to the use of telemedicine for your medical care? Yes____ No____

By providing a telephone number to El Camino Health, its affiliated clinics, or to the patient's referring physician, the patient consents to receive autodialed and prerecorded calls and text messages from El Camino Health, its vendors, and collections agencies relating to the patient's account or relationship with the hospital and clinics, such as for treatment, billing, collections, eligibility for government healthcare programs, and soliciting feedback on care and optimization of the patient experience, as well as for educational and marketing purposes. The patient may opt out of automated calls at any time by calling South Bay Allergy & Asthma at (408) 286-1707.

_____ _____
Patient Name Patient DOB

_____ _____ _____
Parent Name if Applicable Signature Date

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Advanced Beneficiary Notice of Non-Coverage

Your physician has recommended that you undergo a breathing test that monitors the inflammation of your airways that can occur from some diseases such as asthma and is a valuable diagnostic test.

As this testing technology is relatively new, some insurances companies do not consider it a covered test. If your insurance company doesn't pay for Niox testing, you may have to pay. Your insurance company does not pay for everything, even some testing that you and/or your physician have good reason to think you need.

Select one of the following options:

- ☐ **OPTION 1:** I want to have the Niox testing, and I want my insurance company to be billed for an official decision on payment. I understand that if my insurance company doesn't pay, I am responsible for payment.
- ☐ **OPTION 2:** I want to have the Niox testing, but do not bill my insurance company. You may ask me to pay now as I am responsible for payment.
- ☐ **OPTION 3:** I do not want Niox testing. I understand with this choice I am not responsible for payment.

This notice gives our opinion, not an official insurance company decision. By signing below, you have received and understand this notice. You may receive a copy upon request.

Patient Account# _____ *(for office use only)*

_____ _____ _____

Patient Name Signature Date

P.O. Box 997413 MS 4721
Sacramento, CA 95899-7413
(866) 866-0602 or (877) 735-2929 TTY/TTD
http://dhcs.ca.gov/privacyoffice

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Conduct outreach, enrollment, care coordination and case management	• We can share your information with other government benefits programs like Covered California for reasons such as outreach, enrollment, care coordination, and case management.
Appeal a DHCS decision	• We can share your information if you or your provider appeal a DHCS decision about your health care.
Apply for full scope Medi-Cal	• If you are applying for full scope Medi-Cal benefits, we must check your immigration status with the U.S. Citizenship and Immigration Services (USCIS).
Join a managed care plan	• If you are joining a new managed care plan, we can share your information with that plan for reasons such as care coordination and to make sure that you can get services on time.

continued on next page

Administer our programs	• We can share your information with our contractors and agents who help us administer our programs.
Comply with special laws	• There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice.

We will never market or sell your personal information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

- This notice applies to all DHCS programs, including Medi-Cal. For a full list of programs currently run by DHCS, please visit our website at **www.dhcs.ca.gov/services.**

For More Information

Please contact us to request a copy of this notice in other languages or to get a copy in another format, such as large print or Braille.

DHCS does not have full copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor, dentist, or health plan first.

By signing below, I've acknowledged that I was given information about This Notice of Privacy Practices.

DHCS
California Department of HealthCareServices

DHCS Privacy Officer

P.O. Box 997413 MS 4721
Sacramento, CA 95899-7413

Phone: **(866) 866-0602** Option 1, or (877) 735-2929 TTY/TTD
Fax: (916) 327-4556
Email: privacyofficer@dhcs.ca.gov

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered 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 I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature: _____ Date: _____

Confidential Channel Communication Record

As required by the Health information Portability and Accountability Act of 1996, you have a right to request that communications concerning personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contract must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communication I may have made.

Please select:

□ Home #: _____
- □ O.K. to leave detailed message
- □ Only leave call back number

□ Cell #: _____
- □ O.K. to leave detailed message
- □ Only leave call back number

□ Work #: _____
- □ O.K. to leave detailed message
- □ Only leave call back number

□ Fax #: _____
- □ O.K. to leave detailed message
- □ Only leave call back number

What phone number is your preferred contact number? _____

Are there any other adults (18+ years old) who you authorize to receive information pertaining to your care? If so, please list below (along with best contact information):

_____ _____
Contact Name Contact Phone

Signed: _____ Date: _____