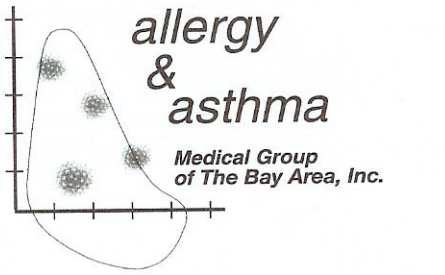

REGISTRATION & TREATMENT AUTHORIZATION
INSURANCE & PAYMENT OBLIGATION Date:_____
MINOR PATIENT DATA:

Patient Name:_____
Last First Initial Sex Birthdate
Address:_____
Street City State Zip
(_____)_____(_____)_____ _____
Home Telephone Cell email
_____
Preferred Language Race (Optional) Ethnicity (Optional)

PARENT Name:_____
Last First Initial Sex Birthdate Marital Status
Address:_____
Street City State Zip
(_____)_____(_____)_____ _____
Home Telephone Cell Employer Name & Address

PARENT Name:_____
Last First Initial Sex Birthdate Marital Status
Address:_____
Street City State Zip
(_____)_____(_____)_____ _____
Home Telephone Cell Employer Name & Address

Is it **OK** to leave a detailed message regarding your account an/or Medical Information on:

- ○ Home Answering Machine ○ Anyone answering **home** phone
- ○ Cell Phone Message ○ Anyone answering **cell** phone
- ○ No If **NO,** is it ok to leave a message to return our call ○ YES ○NO

I authorize (Name of Individual(s))_____
to receive or discuss information related to my diagnosis, records (medical/financial), claims or financial status.

PRIMARY INSURANCE:_____ Group No.:_____

Policy Holder:_____ Ins. I.D. Number:_____

Rel. to Patient:_____ Birthdate:_____ Effective Date:_____

Employer:_____ City, State:_____

SECONDARY INSURANCE:_____ Group No.:_____

Policy Holder:_____ Ins. I.D. Number:_____

Rel. to Patient:_____ Birthdate:_____ Effective Date:_____

Employer:_____ City, State:_____

PRIMARY CARE PHYSICIAN:_____ Address:_____
Who referred you to our office?_____

The parent responsible for the account is the one bringing in the child for treatment

_____ _____
Name of Parent **Signature of Parent**

Please complete other side

Our office policy is to charge all patients (HMO, PPO, Self Pay) a $50 fee for missed appointments or appointments cancelled with less than 24 hours notice.

I Authorize Allergy and Asthma Medical Group to furnish my insurance carrier(s) with any information they request to process my medical claims. I understand that HMO/PPO claims will be submitted on my behalf by the Group only after I have notified the Group of membership and necessary referral has been obtained. I understand that HMO/PPO co-payments are due at the time of services. Charges that are not a benefit of, or not authorized by, my health plan are also my responsibility.

Signature:_____

CLINICAL TRIAL: The Allergy & Asthma Medical Group conducts clinical research trials. We would like to notify patients of studies which may be of interest to them.

_____ You have my permission to contact me.
Initial

_____ I do not wish to be contacted
Initial

Acknowledgement of the Notice of Privacy Practices

The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices.

_____

Signature: Patient, Legal Representative, Agent Date

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is Allergy and Asthma Medical Group's policy to require your reading and signing this consent form prior to the treatment or any other medical services.

I hereby authorize Allergy & Asthma Medical Group to use and disclose my individual identifiable health information for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered and / or engaging in health care operations.

I understand that Allergy & Asthma Medical Group's Notice of Privacy describes in more detail the types of uses and disclosures of Health Information. I understand that I have the right to review such Notice prior to signing.

I understand that I have the right to request a restriction on the use or disclosure on my Health Information. I further understand that Allergy & Asthma Medical Group is not obligated to agree to my request. I have the right to revoke this consent, in writing.

I understand that if I choose not to sign this consent, Allergy & Asthma Medical Group may withhold medical services.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA system and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

_____ _____

Signature: Patient, Legal Representative, Agent Date