PATIENT REGISTRATION

ALLERGY ASTHMA & IMMUNOLOGY OF EAST ALABAMA

PATIENT INFORMATION

Last Name: First Name: Middle Name:

Address: City: State: Zip:

Date of Birth: Social Security Number: ❑ Male ❑ Female

Home Phone: Work Phone: Cell Phone:

Email Address: Preferred Method to Contact You:

Status: ❑Married ❑Single ❑Divorced ❑Widowed

Race: ❑African American/Black ❑Asian ❑Caucasian/White ❑Native Hawaiian/Pacific Islander ❑Other

❑DeclineEthnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Decline

EMERGENCY CONTACTS

Name: Relationship: Phone:

Name: Relationship: Phone:

GUARANTOR INFORMATION (or Person Responsible for Minor)

Last Name: First Name: Middle Initial:

Address: City State: Zip:

Home Phone: Work Phone: Cell Phone:

Date of Birth: Social Security Number:

INSURANCE INFORMATION

Is your visit with us related to a work injury or illness? YES NO

PRIMARY INSURANCE COMPANY NAME: _____

Policy Number: _____ **Group Number:** _____

If Tricare: ❑ Active Standard ❑ Active Prime ❑ Retired Standard ❑ Retired Prime

POLICY HOLDER INFORMATION ❑Check here if Policy Holder is same as Guarantor noted above

Last Name: First Name: Middle Initial:

Date of Birth: Social Security Number: Phone:

Relationship: Employer/Place of Work:

SECONDARY INSURANCE COMPANY NAME: _____

Policy Number: _____ **Group Number:** _____

If Tricare: ❑ Active Standard ❑ Active Prime ❑ Retired Standard ❑ Retired Prime

If Medicare: ❑ Still working of Spouse has Employer Group Health Plan **or**

❑ Disabled Beneficiary under 65 years of age

POLICY HOLDER INFORMATION ❑Check here if Policy Holder is same as Guarantor noted above

Last Name: First Name: Middle Initial:

Date of Birth: Social Security Number: Phone:

Relationship: Employer/Place of Work:

OFFICE POLICIES AND PATIENT RESPONSIBILITIES HANDBOOK

PATIENT BILL OR RIGHTS AND RESPONSIBILITIES:

We believe that all patients receiving services from Allergy Asthma & Immunology of East Alabama should be informed of their rights.

Therefore, you are entitled to:

- Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of service
- Be informed of your financial responsibilities in advance of service / care being provided. Medicare beneficiaries will be informed if assignment is not accepted.
- Receive information about the scope of services that the organization will provide and specific limitations on those services
- Participate in the development and periodic revision of the plan of service
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented
- Be informed of patient rights under state law to formulate an Advanced Directive, if applicable
- Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality
- Be able to identify visiting personnel members through proper identification
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property
- Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
- Confidentiality and privacy of all information contained in the patient record and of Protected Health Information
- Be advised on facility's policies and procedures regarding the disclosure of clinical records
- Choose a health care provider, including choosing an attending physician, if applicable
- Receive appropriate care without discrimination in accordance with physician orders, if applicable
- Be informed of any financial benefits when referred to an organization
- Be fully informed of one's responsibilities

PATIENT RESPONSIBILITIES

- Patient submits forms that are necessary to receive services.
- Patient provides accurate medical and contact information and any changes.
- Patient notifies the treating provider of participation in the services provided by the facility.
- Patient notifies the facility of any concerns about the care or services provided.

When the patient is unable to make medical or other decisions, the family should be consulted for direction.

INSURANCE BILLED AND FEES

Your health insurance policy is a contract between you and your health insurance company. Allergy Asthma & Immunology of East Alabama, LLC is not a party to that contract. Our relationship is with you, not your insurance company. As a courtesy to you, we file claims directly with your insurance company. We are affiliated with the most common insurance companies. If your insurance company is not listed on our website, then please ask if we are able to file claims with your insurance before services are rendered.

Deductibles, co-payments, and co-insurance are required by your health insurance company and were agreed upon by you when you accepted their insurance contract. Allergy Asthma & Immunology of East Alabama must contract with insurance companies agreeing to collect such deductibles, co-payments, and co-insurance in order to participate with their insurance plan. Co-payments and co-insurance must be collected at the time services are rendered. **There will be a $15 fee if we must bill you for the co-payment or co-insurance if not paid on the day of service.**

Your insurance company will send you a report (Explanation of Benefits or a Processed Claim Report) showing what we charged, what they adjusted per contracted rate, and what they paid on your behalf. This is not a bill or statement from Allergy Asthma & Immunology of East Alabama. We receive a similar document and must process this information, review the claim, and re-file the claim if needed. As a result, statements to you from Allergy Asthma & Immunology of East Alabama are often delayed two months or longer as we attempt to collect from your insurance company. If your insurance company has not paid to Allergy Asthma & Immunology

of East Alabama the submitted charges within 90 days, then you will be responsible for the full amount charged and you will need to pursue direct reimbursement from your insurance company.
If your insurance requires you to be seen by your primary care physician before being referred to Allergy Asthma & Immunology of East Alabama, such as East Alabama Medical Center's Point of Service plan, then it is your responsibility to have this done in advance. With such plans, your primary care provider must generate all referrals for any specialist, ER visit, x- ray study or outpatient procedure. If not, then the claim will be denied by your insurance plan and the charges will be your responsibility. Additionally, for such plans, if a specialist recommends another doctor or test, you must still get the referral from your primary care doctor or the claim will be denied, and the cost will be your responsibility. Referrals must be made before a visit; however backdated referrals may be made in emergent situations as defined by your plan and regulations posted by your primary care physician.

As our patient, we want to provide you the best care possible. Often, we need to diagnose conditions by testing, such as skin testing for allergies or lab tests for hives and treat conditions using medications and shots. We consider these diagnostic and treatment protocols as standard of care and medically necessary. Unfortunately, there are some insurance plans that have a $200 cap per year on what they will pay for when it comes to allergy testing and treatment, or they may simply refuse to pay for a procedure or treatment that theymay deem medically unnecessary. It is essentially impossible for us to know which insurance plans maintain such policies. Rather, it is you, the card holder, who is responsible for being aware of your insurance company's coverage policies. If you have any questions regarding whether or not a particular service is covered, please check with your insurance company first. All charges are your responsibility whether or not your insurance covers them. If allergy shots are not covered by your insurance company, then you may discuss with our billing department a payment plan.

Please keep in mind that most insurance companies require you to meet your deductible before your coverage begins. It is essentially impossible for us to know what your deductible is, which varies from zero to thousands of dollars depending on your insurance type.

Self-pay patients must pay for services in full at the time services are rendered. Payment plans are not available for office visits. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect that amount from the other parent. If you have an unpaid balance over 60 days, you will be required to pay your balance in full before beingseen in our office.

There is a $25 fee for a returned check or any payment from you that does not clear properly for any reason. This fee offsets the fee charged by our bank, as established by law. This fee is in addition to the payment that was being made by the returned check. We reserve the right to contact the Lee County District Attorney's Worthless Check Unit for assistance collecting these payments pursuant to Section 12A-9-13.2 of the Code of Alabama.

If your records must be sent to another doctor or organization, then a signed written request is required and a copying fee of $1.00 per page for the first 25 pages and $0.50 per page thereafter will be due in full. The Medical Records Release Form, which is a HIPAA requirement, is available at our office and on our website at Infusioncare.org.

A receipt for a co-payment or co-insurance payment will be provided to you on the day of service only. If a receipt is requested at a later day, there will be a $1 charge per receipt.

Any credit or refund due to you will be applied toward future charges by Allergy Asthma & Immunology of East Alabama. If there are no charges in the subsequent 12-month period, then you may receive the credit or refund by contacting our billing department.

Our office policy is to put medical evaluation and treatment, on hold for any patient who has an outstanding balance of $250.00 or greater.

The following are fees that must be paid before the paperwork will be released to the patient:

- FMLA - $25.00
- Detailed Letter / Statement / Form - $20.00
- A $5.00 fee will be charged if the paperwork / form needs to be expedited (5 business days)

CANCELLATION AND NO-SHOW POLICIES

It is the policy of Allergy Asthma & Immunology of East Alabama that patients need to report for their scheduled appointments. In the case that a patient is unable to make the scheduled appointment, the patient must give 24 hours advanced notice to the front office staff by calling (334) 528-0078, otherwise your chart will be marked as a No-Show for that visit. In the event a 24-hour notice is not given, then the following fees are applied: $50 for missed office visit or up to $50 for missed scheduled procedure. You will be notified of such fee, which will be due prior to the next scheduled appointment.

TERMINATION POLICY

ALLERGY ASTHMA & IMMUNOLOGY OF EAST ALABAMA reserves the right to terminate our relationship with the patient if:

- Three (3) or more appointments are missed consecutively.
- Three (3) or more appointments are missed in a twelve (12) month period.
- The patient does not follow the appropriate guidelines of therapy as directed by the physician(s), including butnot limited to asthma controller medications and allergy shots.
- The patient's or the patient's caregivers' behavior and/or actions are offensive to Allergy Asthma & Immunology of East Alabama Staff or Allergy Asthma & Immunology of East Alabama Patients.

QUEST DIAGNOSTICS LAB

- Labs drawn inside our office are processed and billed to your insurance through a third party, Quest Diagnostics. If your insurance requires your labs to be processed by a different company, please notify our staff.
- Any questions regarding a bill from Quest Diagnostics, please contact them at (866) 697-8378

HIPAA PRIVACY NOTICE

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.

OUR COMMITMENT TO YOUR PRIVACY

It is our duty to maintain the privacy and confidentiality of your protected health information (PHI). We will create records regarding your and the treatment and service we provide to you. We are required by law to maintain the privacy of your PHI, which includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the facility.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from our Privacy Officer.

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of treatment, payment, and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

Treatment means providing services as ordered by your physician. Treatment also includes coordination and consultations with other health care providers relating to your care and referrals for health care from one health care provider to another. We may also disclose PHI to outside entities performing other services related to your treatment such as hospital, diagnostic laboratories, home health or hospice agencies, etc.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, prior approval, determinations of eligibility and coverage and other utilization review activities. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release, when necessary, under applicable law.

Health care operations means the support functions of the facility, related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews,

compliance programs, audits, business planning, development, management, and administrative activities. We may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.
- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- To disclose to your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment that it is in your best interest to make such disclosures.

We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.

We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

We will use or disclose PHI about you when required to do so by applicable law.

In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer, or the facility as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

Pharmacy Benefit Management (PBM)

Electronic–Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Medication History Transactions provide the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent, you are agreeing that Allergy Asthma & Immunology of East Alabama can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for optimal treatment purposes.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

- Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.
- Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:
  - to prevent or control disease, injury, or disability.
  - to report births and deaths.
  - to report child abuse or neglect.
  - to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products.
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
  - to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:
- In response to a court order, warrant, summons, or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime under certain limited circumstances.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct on our premises; or
- In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment, and health care

operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you may make your request in writing to the Privacy Officer.

You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer.

You have the right to inspect and copy the PHI contained in our facility records, except:

- for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record).
- for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
- for PHI involving laboratory tests when your access is restricted by law.
- if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you.
- if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research.
- for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and
- for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect or obtain a copy your PHI, you may submit your request in writing to the Medical Records Custodian. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request. We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

You have the right to request an amendment to your PHI, but we may deny your request for amendment, if we determine that the PHI or record that is the subject of the request:

- was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment.
- is not part of your medical or billing records or other records used to make decisions about you.
- is not available for inspection as set forth above; or
- is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to Medical Record Custodian at our facility, along with a description of the reason for your request.

You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above.
(ii) incidental to a use or disclosure otherwise permitted or required by applicable law.
(iii) pursuant to your written authorization.

- to persons involved in your care or for other notification purposes as provided by law.
- for national security or intelligence purposes as provided by law.
- to correctional institutions or law enforcement officials as provided by law.
- as part of a limited data set as provided by law.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer at our facility. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the facility's Privacy Officer. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services, 200 Independence Ave. S.W., Washington DC, 20201.

INFECTION CONTROL

The patient/caregiver should observe all healthcare workers they meet and encourage and remind healthcare workers to wash their hands prior to providing care.

Items that touch only intact skin (e.g., blood pressure cuff, stethoscopes, thermometers, and other medical accessories) rarely, if ever, transmit disease. These items will be cleaned with alcohol after each use. Should any piece of item become contaminated with blood or other potentially infectious material, the item should be cleaned with a chemical germicide.

All excretions, secretions, blood, and drainage should be discarded in the toilet.

To minimize contamination during use, products must be handled in a manner that will protect them from contamination. These procedures include the following:

- Wash hands, making sure to use good hand washing technique.
- Unpack and handle products in a manner consistent with preservation of optimal cleanliness.
- Properly store all products

MAKING DECISIONS ABOUT YOUR HEALTH CARE

Advance Directives are forms that say, in advance, what kind of treatment you want or do not want under serious medical conditions. Some conditions, if severe, may make you unable to tell the doctor how you want to be treated at that time. Your Advance Directives will help the doctor to provide the care you would wish to have.

Most hospitals and home health organizations are required to provide you with information on Advance Directives. Many are required to ask you if you already have Advance Directives prepared.

This pamphlet has been designed to give you information and may help you with important decisions. Laws regarding Advance Directives vary from state to state. We recommend that you consult with your family, close friends, your physician, and perhaps even a social worker or lawyer regarding your individual needs and what may benefit you the most.

What Kinds of Advance Directives Are There?

There are two basic types of Advance Directives available. One is called a Living Will. The other is called a Durable Power of Attorney.

A Living Will gives information on the kind of medical care you want (or do not want) become terminally ill and unable to make your own decision.

It is called a "Living" Will because it takes effect while you are living.

- Many states have specific forms that must be used for a Living Will to be considered legally binding. These forms may be available from a social services office, law office, or possibly a library.
- In some states, you are allowed to simply write a letter describing what treatments you want or do not want.
- In all cases, your Living Will must be signed, witnessed, and dated. Some states require verification.

A Durable Power of Attorney is a legal agreement that names another person (frequently a spouse, family member, or close friend) as an *agent* or *proxy.* This person would then be making medical decisions for you if you should become unable to make them for yourself. A Durable Power of Attorney can also include instructions regarding specific treatments that want or do not want in the event of serious illness.

What Type of Advance Directive is Best for Me?

- This is not a simple question to answer. Each individual's situation and preferences are unique.
- For many persons, the answer depends on their specific situation, or personal desires for their health care.
- Sometimes the answer depends on the state in which you live. In some states, it is better to have one versus the other.
- Many times, you can have both, either as separate forms or as a single combined form.

What Do I Do If I Want an Advance Directive?

- First, consult with your physician's office or home care agency about where to get information specific for your state.
- Once you have discussed the options available, consult with any family members or friends who may be involved in your medical care. This is extremely important if you have chosen a friend or family member as your "agent" in the Durable Power of Attorney.
- Be sure to follow all requirements in your state for your signature, witness signature, notarization (if required), and filing.
- You should provide copies of your Advance Directive(s) to people you trust, such as close family members, friends and/or caregiver(s). The original document should be filed in a secure location known to those to whom you give copies.
- Keep another copy in a secure location; if you have a lawyer, he or she will keep a copy as well.

How Does My Health Care Team Know I Have an Advance Directive?

- You must tell them. Many organizations and hospitals are required to ask you if you have one. Even so, it is a good idea to tell your physicians and nurses that you have an Advance Directive, and where the document can be found.
- Many patients keep a small card in their wallet that states the type of Advance Directive they have, where a copy of the document(s) is located, and a contact person, such as your Durable Power of Attorney "agent," and how to contact them.

What If I Change My Mind?

- You can change your mind about any part of your Advance Directive, or even about having an Advance Directive, at any time.
- If you would like to cancel or make changes to the document(s), it is very important that you follow the same signature, dating, and witness procedure as the first time, and that you make sure all original versions are deleted or discarded, and that all health care providers, your caregiver(s), your family and friends have a revised copy.

What If I Do not Want an Advance Directive?
You are not required by law to have one. Many home care companies are required to provide you with this basic information, but what you choose to do with it is entirely up to you.

For More Information...
This pamphlet has been designed to provide you with basic information. It is not a substitute for consultation with an experienced lawyer or knowledgeable social worker. These persons, or your home care agency, can best answer more detailed questions, and help guide you towards the best Advance Directive for you.

GRIEVANCE / COMPLAINT REPORTING
You may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call (334) 528-0078 and speak to customer services. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.

You may also make inquiries or complaints about this facility by calling Medicare at 1-800-MEDICARE and/or the Accreditation Commission for Health Care (ACHC) at (919) 785-1214.

Patient Consent Form

Today's Date_____

Patient Name: _____

Date of Birth: _____

_____ (Initials) I have read and understand the OFFICE POLICIES AND PATIENT RESPONSIBILITIES and agree to all terms andconditions set forth herein.

_____ (Initials) I have received the *Notice of Privacy Practice* from Allergy Asthma & Immunology of East Alabama, LLC. I understand that I may request a copy of Notice by asking the receptionist. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice,my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its *Notice of Privacy Practices* and to makechanges regarding all protected health information under the control of this practice.

_____ (Initials) Evaluation and Treatment. I consent to diagnostic procedures and medical care as deemed necessary in the judgment of my Physician. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me. However, I understand that my Physician will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

_____ (Initials) Government Compliance. In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, Allergy, Asthma & Immunology of East Alabama must inform you that there are other options pertaining to infusion and pharmacy services. Specifically, it should be noted that you have presented to Allergy, Asthma & Immunology of East Alabama voluntarily for your medical needs and that as part of the evaluation of your condition and any required treatment, the clinician may determine that particular infusion and/or pharmacy services may be needed. Infusion Care and Medicus Specialty Pharmacy offer many of these services on-site as a convenience to our patients. If any patient would like to have their infusion and pharmacy services provided at another location, we can provide you with a list of nearby locations. I have been informed of the infusion and pharmacy services which are available within a 25-mile radius. If I have no preference in providers, Infusion Care and/or Medicus Specialty Pharmacy will be utilized. I am aware Allergy, Asthma & Immunology of East Alabama has interest in those businesses. I authorize Allergy, Asthma & Immunology of East Alabama to release the necessary information concerning my case history, treatment, and examination for my visit to the above-named businesses.

By signing below, I hereby and understand the following Office Policies and Patient Responsibilities Handbook, Notice of Privacy Practices, Evaluation and Treatment, and Government Compliance:

Signed:_____ Date:_____
Patient

Signed:_____ Date:_____
Guardian

Permission to Release Medical Information

I give permission for my medical information to be discussed with the below listed individuals/Doctors:

Name:_____ Name: _____

Relationship to patient:_____ Relationship to patient:_____

Phone number:_____ Phone number: _____