Connecticut Asthma & Allergy Center LLC

Registration Form

Name: ____ Date of Birth: ____/___/______
Last First Middle Initial

Sex: ____Race: ____ Ethnicity: _______Language: ___Marital Status _____Email: _________________

Address: ____
\# Street Apt/PO Box Town State Zip Code

Phone: (____)____________(Hm/Work/Cell) Secondary Phone: (____)____________(Hm/Work/Cell)
Circle One Circle One

Employer: ______________________(______)__________________ Full Time Part Time Retired
Name Phone Number Circle One

Primary Care: ____
Name Town Phone Number

Referring Physician: ____
Name Town Phone Number

Emergency Contact/Relation:________________________________(___)_______-________
First and Last Name Phone Number

Parent / Guardian Information (if Child)

Name: ____
Last First Middle Initial Relationship to Patient

Date of Birth: ____/___/______ Email: ____

Employer: ______________________(______)__________________ Full Time Part Time Retired
Name Phone Number Circle One

Name: ____
Last First Middle Initial Relationship to Patient

Date of Birth: ____/___/______ Email: ____

Employer: ______________________(______)__________________ Full Time Part Time Retired
Name Phone Number Circle One

Insurance Information

Primary Insurance: ____
Plan Name ID Number Group Number

Policy Holder Information: _________________ (____)______________ ___/______/______
First and La Phone Number Date of Birth

____
Relationship to Patient Street Address Town State Zip Code

Secondary Insurance: ____
Plan Name ID Number Group Number

Policy Holder Information: _______________________ (____)______________ ___/______/______
First and Last Name Phone Number Date of Birth

____
Relationship to Patient Street Address Town State Zip Code

Signature: ____**Today's Date**: _______________

Print Name: ____

Marshall P. Grodofsky, MD
Jeffrey M. Factor, MD
Jason O. Lee, MD
Jasmine Abbosh, MD
Gavin Schwarz, MD
Hillary. Hernandez-Trujillo, MD
Wei An, MD
Olivia DelloStritto, PA-C

Informed Consent

I authorize:

- Connecticut Asthma & Allergy Center LLC (CAAC) to forward any medical information to any of my health care providers regarding my/my child's illness and treatment and to submit information to my employer and/or their insurance carrier (for workers' compensation only). I understand the information released may include psychiatric, drug, alcohol, and/or HIV/AIDS information. The confidentiality of this record is protected by the Federal Confidentiality Regulations 42 CFR 9 part 2 and chapter 899c of the Connecticut General Statutes. This information shall not be forwarded to anyone else without my written consent or other authorization as provided in the statutes.
- CAAC to release to the insurance carrier any information needed for the payment of any claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
- CAAC to complete forms or documents submitted for schools, camps, FMLA, certification of illness, and other medical necessity needs.
- Payment to CAAC from my insurance carrier and agree to pay any applicable co-payments at the time of service. I understand that my health insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance.
- Testing and treatment procedures as deemed necessary by the CAAC physicians.
- Due to the fact that the patient ________________ is relying on his/her parents medical policy for the partial payment of the charges incurred for services rendered, Patient hereby agrees to allow this medical office and/or its representatives to contact the parent policy holder regarding insurance payments, denials, co-pays, co-insurance, deductibles, balances owed, explanations of benefits, ID numbers, changes in insurers and related issues. I further agree to be financially responsible for payment of all amounts not paid or adjusted off by insurance. In the event of non-payment, I agree to bear the cost of collection including any reasonable legal fees required to obtain payment.

I CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I AM THE PATIENT (OR THE MEDICAL POLICY HOLDER) AND I ACCEPT THE TERMS AS ABOVE.

____ ________________

Patient / Medical Policy Holder Date

If patient is a minor:

____ ________________

Signature of Responsible Party Date

____

Relationship to patient

If you have been assigned guardianship of the minor patient, you must present proof of guardianship, such as a court document or DCF paperwork.

For office use only. To be completed by CAAC staff

______________________________________ ______________________________

Patient Name MR# Staff Initials

Marshall P. Grodofsky, MD
Jeffrey M. Factor, MD
Jason O. Lee, MD
Jasmine Abbosh, MD
Gavin Schwarz, MD
Hillary. Hernandez-Trujillo, MD
Wei An, MD
Olivia DelloStritto, PA-C

Written Acknowledgement of Receipt of Privacy Notice

Patient Name:________________________ MRN:___________________

Date of Birth:_________________________

I, ____________________________, herby acknowledge that I have been offered a copy of
(Patient/Parent or Guardian)
Connecticut Asthma & Allergy Center's Privacy Notice.

I also understand that if Connecticut Asthma & Allergy Center changes or adds to the Privacy Notice, I am entitled to an updated copy upon request.

Authorization to leave medical information on voicemail

I, ____________________________, approve the clinical staff of Connecticut Asthma & Allergy
(Patient/Parent or Guardian)
Center to leave medical information on the following phone number: _____________________

I, ____________________________, do not approve the clinical staff of Connecticut Asthma &
(Patient/Parent or Guardian)

Allergy Center to leave medical information on my voicemail.

(OVER)

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Authorization to Share Confidential Information

I hereby authorize the following people to share any and all confidential information from my/my dependent's care and treatment provided by Connecticut Asthma & Allergy Center LLC. I understand that this includes medical and/or billing information in written or telephone discussion.

1) Name ___________________________ Relationship________________________

   Telephone number(s) for verification purposes _____________________________

2) Name ___________________________ Relationship________________________

   Telephone number(s) for verification purposes _____________________________

Signature: _________________________________ Date: ____________________

Relationship to Patient: _____________________________________

If I wish to rescind this authorization, I understand that I must provide a written note to:

HIPAA Privacy Officer
Connecticut Asthma & Allergy Center LLC
836 Farmington Ave., Suite 207
West Hartford, CT 06119-1551

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Financial Policy

This is an agreement between Connecticut Asthma & Allergy Center, LLC, and the Patient/Parent of minor patient named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Parent of minor patient. The word "account" means the account that has been established in your name or your minor child's name to which charges are made and payments credited. The words "we," "us," and "our" refer to Connecticut Asthma & Allergy Center, LLC.

By executing this agreement, you are agreeing to pay for all services that are received.

Please Initial:

______ Monthly Statement: **If you have a balance on your account, we will send you a monthly statement. Unless other arrangements have been approved by us in writing, the balance is due and payable in full upon receipt.**

______ Contracted Insurance: **Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.**

______ Non-contracted Insurance/Out of Network: **If you have insurance coverage under a plan in which we do not participate, you will be treated as a self-pay patient and FULL payment is due at the time of service.**

______ Referrals and Pre-authorizations: **It is your responsibility to check with your insurance regarding referrals/pre-authorization BEFORE your appointment. If your insurance does not pay because you did not obtain the referral/pre-authorization, you will be responsible for the full amount due.**

______ Returned Checks: **The charge for returned checks is currently $20.00 and will be billed to your account.**

______ No show/ Late cancellations: **Cancellation of office appointments (excluding shot appointments) are required at least 24 hours prior to the appointment. A charge of $50.00 for missed or late-canceled appointments will be billed to your account. This charge is not covered by insurance and must be paid before any further appointments can be scheduled.**

______ Past due accounts: **If you have a balance that is past due, this balance must be paid in full prior to scheduling your next appointment. Payment plans can be arranged by contacting our billing department. If your account becomes past due, we will take necessary steps to collect this debt. Collection of debts may be made by referring debts to a collection agency, an attorney or court. You agree to pay all charges that we incur in collection of this account, including court costs and attorneys' fees.**

______ Waiver of Confidentiality: **You understand if this account is submitted to an attorney or collection agency and/or if we have to litigate in court, the fact that you received treatment at our office may become a matter of public record.**

______ Divorce: **In case of divorce or separation, the patient is responsible for payment of the account. If the divorce decree requires the other party to pay all or part of the treatment costs or to carry insurance for the patient, we will file the insurance if the information is provided to us. However, it is the responsibility of the patient to pay all balances due and to collect unpaid amounts from the other party.**

______ Minor Children of Divorced Parents: **After a divorce or separation, both parents are responsible for those 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 from the other parent. It is also the responsibility of the authorizing parent to provide accurate billing and employment information on the responsible parent.**

______ Adults 18-26 years old: **In initialing this paragraph, you certify that you are the adult who is responsible for payment of all charges for services rendered. However, you listed your parent's insurance as your insurer. This insurer will be billed for the charges for the services rendered but you are responsible for all balances and co-pays.**

______ Adults 18-26 years old: **In initialing this paragraph, you specifically authorize us to disclose your Protected Health Information to your parent(s) as the subscriber of your health insurance policy in order to expedite payment of your account. You have the right to revoke this authorization, in writing, by sending such written notification to this office. You understand that we are not responsible for consequences of the disclosure of information which may have been disclosed prior to the date of the revocation.**

Effective Date: **Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.**

Patient's Name: ____

Responsible Party (if not the patient):____

Signature: ____ Date: ______________________

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PRIVACY NOTICE

Your privacy and trust is of the utmost importance to Connecticut Asthma & Allergy Center LLC (CAAC). The providers of CAAC make every reasonable effort to ensure that any information you provide and that is maintained by us is private, confidential, and secure. CAAC clearly and fully discloses our security and privacy practices.

This is to notify you of all uses and disclosures that CAAC may make of your/your dependent's protected health information (PHI). *Please review it carefully*. If you have any questions or concerns about this notice, please call HIPAA Privacy Officer at (860) 232-9911.

OUR RESPONSIBILITIES TO OUR PATIENTS

We are required by law to:

1. Maintain the privacy of our patient's health information and to provide a Privacy Notice to our patients.
2. Comply with the terms of the current Privacy Notice. We reserve the right to change or add to our privacy practices. Should any changes occur, we would make the revised Privacy Notice available to you by posting it in our waiting room.

YOUR RIGHTS REGARDING YOUR/YOUR DEPENDENT'S HEALTH INFORMATION

1. You have a right to access your/your dependent's medical record. You may inspect and, upon written request obtain a copy of the medical record. Request for Release of Medical Records Forms are available at the front desk. In certain circumstances, guardianship papers may need to be submitted with your written request. Connecticut General Statute §20-7c allows the physicians to charge 65 cents per page plus the cost of first class postage. Payment is due in full before medical records will be released. The physicians of CAAC will continue to provide medical records to your treating physician(s) at no charge.
2. You have a right to alternative communication. You have the right to request that we communicate with you concerning the patient's health matters in a confidential manner or in a private location. For example, you may request to be moved into a closed room to discuss your PHI. Our staff will accommodate any reasonable request.
3. You have a right to amend your/your dependent's medical record. Any amendment you request must be made in writing and must state the reason you are requesting it. We may deny your request if the information: [a] was not created by CAAC, unless you provide reasonable information that the person who created the information is no longer available to respond to your request; [b] is information to which you do not have a right of access; or [c] is already accurate and complete, as determined by us. If CAAC denies your requested amendment, we will notify you in writing, including the reason for our denial. You have a right to send a letter disagreeing with the denial. If you choose to send one, it will be attached to the medical record.
4. You have a right to request restrictions on uses and disclosures of your/your dependent's PHI. You may request that we restrict the way we use or disclose the health information for treatment, payment, or healthcare operations. CAAC is not required to agree to the restriction. If we do agree to a restriction, we will honor that restriction except in the event of an emergency. In an emergency, we will only disclose the minimum necessary for treatment.
5. You have a right to an accounting of disclosure. This is a listing of disclosures made by CAAC, but does not include disclosures for treatment, payment, and healthcare operations. You must submit your request in writing specifying the time period you are requesting. The listing will include: [a] the disclosure date; [b] the name of the recipient, including the address, if known; [c] a brief description of the information sent; and [d] a brief statement of the purpose of the disclosure. You may be charged for the costs for completing the accounting.
6. You have a right to complain. Should you feel that your/your dependent's privacy rights have been violated, or have any complaint regarding our Privacy Practices, please file a written complaint to CAAC's HIPAA Privacy Officer, Amanda Phillips. Her office is in the main office at West Hartford. CAAC will not retaliate against you in any way for filing a complaint.
7. You have a right to a paper copy of this notice. You may request a copy at any time. It is also available at our website, www.ctallergy.net.

HOW WE USE AND DISCLOSE YOUR/YOUR DEPENDENT'S HEALTH INFORMATION

The following categories describe the different ways we may use and disclose your/your dependent's health information.

1. **For treatment.** We may use and disclose health information to provide you with treatment and services and to coordinate your continuing care. The information may be used by doctors, nurses, labs, specialists, or other personnel involved in your care. For example, we may ask you to have laboratory tests and we may use the results to help us reach a diagnosis. A pharmacist will need certain information to fill a prescription ordered by your doctor. We may also disclose your health information to persons or facilities that will be involved in your care after you leave our office.
2. **For payment.** We may use and disclose health information so that we can bill and receive payment for the treatment and services you receive. For example, we may contact you health insurer to certify your eligibility for benefits or to request prior authorization for a proposed treatment or service. We may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment.
3. **For health care operations.** We may use and disclose health information as necessary for our internal operations, such as for general administration activities and to monitor the quality of care you receive with us. For example, we may use information to evaluate and improve the quality of care you received, for education and training purposes, or to conduct cost-management and business planning activities for our practice.
4. **Appointment reminders.** We may use and disclose health information to contact you and remind you of an appointment.
5. **To avert a serious threat to health or safety.** We may use and disclose health information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another individual. Information will only be disclosed to someone able to lessen or prevent the threatened harm.
6. **National security.** We may use and disclose health information as needed to provide protection to the President of the United States, certain other persons or foreign heads of states, or to conduct certain special investigations as authorized by law.
7. **Workers' compensation.** We may use and disclose health information to comply with laws relating to workers' compensation or similar programs.
8. **Reporting victims of abuse, neglect, or domestic violence.** If we believe that a patient has been a victim of abuse, neglect, or domestic violence, we may use and disclose health information to notify a government authority, if authorized by law or if you agree to the report.
9. **Health oversight activities.** We may disclose health information to a health oversight agency, a state or federal agency that oversees the healthcare system, for activities authorized by law. Some of the activities may include audits, investigations, and inspections.
10. **Treatment options.** We may use and disclose health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.
11. **As required by law.** We may use and disclose health information when required by law to do so.

We are part of an Organized Health Care Arrangement (OHCA) with the Hartford Physicians Association, Inc. and its other members for the purpose of engaging in certain medical management, utilization review, quality assessment and improvement, and data aggregation activities. We may use and disclose your PHI without your consent in connection with the operations of the OHCA. No member of the OHCA shall be liable or otherwise responsible in any manner for the acts or omissions of any other member of the OHCA by reason of its participation in such arrangement.

Your written authorization is required for all other uses or disclosures of your/your dependent's health information. CAAC will obtain your written authorization prior to making any disclosures. The authorization will expire after six months. You may revoke your written authorization, in writing, and we will no longer disclose the health information except where we have already taken actions in reliance on your authorization. Psychiatric, HIV/Aids-related information, and substance abuse treatment information requires a specific written authorization. A general authorization for release of medical information will not be sufficient for purposes relating to this information.