



ALLERGY & ASTHMA  
MEDICAL GROUP OF THE BAY AREA

**REGISTRATION & TREATMENT AUTHORIZATION  
INSURANCE & PAYMENT OBLIGATION  
MINOR PATIENT DATA:**

Date: \_\_\_\_\_

**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.

I authorize AAMG to send text message reminder calls to Cell Phone #: \_\_\_\_\_

**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 and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the health 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 health system only with the patient's express authorization or as otherwise specifically permitted or required by law.

\_\_\_\_\_  
Signature: Patient, Legal Representative, Agent

\_\_\_\_\_  
Date

### **ACKNOWLEDGEMENT OF POLICY REGARDING PATIENT INTERACTIONS WITH STAFF**

We value you as a patient and want to continue to provide you with high-quality care and service. To do so, we need to set boundaries and expectations that will foster an effective provider-patient relationship. AAMG staff will provide the best possible care for the patient and their family and/or guests. In return AAMG expects reciprocal behavior from our patients and their family and/or guests. Behavior that is considered rude, threatening, demeaning or disruptive and which interferes with the staff's ability to provide patient care will result possible termination of care.

\_\_\_\_\_  
Signature: Patient, Legal Representative, Agent

\_\_\_\_\_  
Date