OAC
OKEMOS ALLERGY CENTER

3955 Okemos Rd, Ste A1
Okemos, MI 48864
517-349-0027

Dear Patient,

Welcome to our office. Enclosed, please find your registration materials.

PLEASE COMPLETE THIS PAPER WORK PRIOR TO YOUR ARRIVAL. ELECTRONIC REGISTRATION CAN BE COMPLETED ON PATIENT PORTAL LOCATED ON OUR WEBSITE: OKEMOSALLERGYCENTER.COM. WE MUST HAVE YOUR EMAIL ADDRESS IN ORDER TO ACTIVATE YOUR PORTAL ACCESS.

IMPORTANT: PLEASE REVIEW THE MEDICATION INFORMATION SHEET AT LEAST 5 DAYS PRIOR THE APPOINTMENT. SOME MEDICATIONS MAY INTERFERE WITH ALLERGY TESTING. FAILURE TO READ THIS INFORMATION MAY CAUSE YOUR APPOINTMENT TO BE RESCHEDULED.

Allow 2 to 3 hours for this appointment.

We require payment of co-payments at the time of service. Allergy testing costs will vary depending on the number of items that you are being tested for. If your insurance plan has a deductible, please be aware the cost of the allergy testing may be applied to your deductible. We strongly suggest you review your insurance plan and make note of any possible out-of-pocket costs. It is your responsibility to know your insurance plan and coverage details.

If you have any questions, please call our office. We look forward to your visit.

Regards,

Manoj Mohan, D.O.
Andrea Miller, N.P.
Lawrence Hennessey, M.D., Retired
Kamal Mohan, M.D., Founder, Retired

Important Medication Information for Allergy Testing

Anti-histamines and other medications can interfere with allergy skin testing. Please review the following list of medications that need to be stopped prior to your visit. It is not necessary to stop taking Decongestants unless they are combined with antihistamines.

DO NOT STOP TAKING YOUR ASTHMA MEDICATIONS

Antacids:

Stop these for 2 Days:

Axid, Pepcid, Tagamet, Tums Ultra, and generic famotidine, cimetidine, and nizatidine, both Rx and OTC.

You can continue taking: Prevacid, Prilosec, Nexium and other "PPI" drugs (lansoprazole, omeprazole, etc.).

Prescription Antihistamines:

Stop these for 2 Days:

Astelin and Dymista (Azelastine), Patanase (olopatadine nasal), Bromfed, Dimetane, Kronofed, and generics.

OTC Antihistamines:

Stop these for 2 Days:

Benadryl and generic diphenhydramine, Actifed, Contac, Chlor-Trimeton and generic chlorpheniramine, Tavist and clemastine OTC strength, Dimetapp and generic brompheniramine, Allegra 30 mg, 60 mg, Allegra-D 12 Hour, and all generic low-dose fexofenadine products, Histex and generic triprolidine.

Prescription Antihistamines:

Stop these for 5 Days:

Atarax, Vistaril, and all generic forms of hydroxyzine), Periactin and generic cyproheptadine, prescription levocetirizine, Karbinal, Arbinoxa, and generic carbinoxamine, dexchlorpheniramine, prescription-strength Tavist and clemastine.

OTC Antihistamines:

Stop these for 5 Days:

All types of Claritin, Alavert, Tavist Non-Drowsy formula and all generic loratadine products, Zyrtec, Zyrtec D, and all generic cetirizine products, Allegra 180, Allegra D 24 hour, and all generic fexofenadine 180 mg products, Xyzal and generic levocetirizine.

Prescription Antihistamines:

Stop these for 6 Days:

Clarinex, Clarinex D, and generic desloratadine.

Anti-Anxiety/Depressants:

Stop for 3 days: Elavil, Limbitrol, and generic amitryptiline (minimum 3 days, 7 days is preferred).

Stop for 5 days: Seroquel and generic quetipiane.

Stop for 7 days: Sinequan and generic doxepin.

Anti-Nausea:

Stop these for 3 days:

Antivert and generic meclizine, Compazine and generic prochlorperazine, Dramamine and generic dimenhydrinate, Phenergan and generic promethazine, Tigan and generic trimethobenzamide.

Muscle Relaxants:

Stop these for 5 days:

Flexeril and generic cyclobenzaprine.

Sleep aids:

Stop these for 2 days:

Tylenol PM, Excedrin PM, Advil PM, Nyquil, Z-Quil, Sominex, and related generics.

ADULT PATIENT REGISTRATION FORM
(P l e a s e P r i n t)

Personal Information

Please check here if you're a former patient: _____

Patient's Legal Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home/Cell Phone: _____ Work Phone: _____

Email Address: _____

Date of Birth: _____ Birth Sex: _____ Male _____Female

Sexual Orientation: _____ Straight or Heterosexual _____ Gay, Lesbian, Homosexual, Bisexual

_____ Choose not to disclose

Gender Identity: _____ Male _____ Female _____ My chosen gender identifier

_____ Choose not to disclose

Marital Status: _____ Married _____ Divorced _____ Single _____Widowed

Race: _____ Ethnicity: _____

Occupation: _____

Employer: _____

Communication Preference: _____ Phone: Leave Message
_____ Phone: Do not Leave Message
_____ Email
_____ Patient Portal
_____ Text
_____ No Preference

Primary Care Physician: _____

Referring Physician: _____

In Case of Emergency Notify: _____

Relationship to Patient_____

Phone: _____

If you desire another person to contact us on your behalf regarding chart information, appointments or billing information, please provide their name(s) and relationship.

_____ _____
Name Relationship

_____ _____
Name Relationship

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Relationship to Patient: _____

Date of Birth: _____

Contract No. _____ Group No. _____

Co-pay Amount (if any) $_____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Secondary Insurance: _____

Subscriber's Name: _____

Relationship to Patient: _____

Date of Birth: _____

Contract No. _____ Group No. _____

Co-pay Amount (if any) $_____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

PHARMACY INFORMATION

Preferred Retail Pharmacy: _____

Preferred Mail Order Pharmacy: _____

Prescription Drug Plan: _____

FINANCIAL POLICY

In order for us to provide the best possible care and to maximize your medical insurance policy coverage, you must provide accurate insurance information. This includes providing current insurance card(s) and informing our staff of any recent changes, including employment, coverage, phone number and address.

The relationship you have with your insurance company and employer is a contract of which we are not part of. Our billing staff will process medical claims for you and answer any questions you may have. **Please be advised, regardless of your insurance status, final responsibility for payment of our services is your obligation**. There are some insurance companies that require an authorization before allergy treatment will be paid; others have their own insurance guidelines about coverage for visits to a specialist's office. ***It is your responsibility to know the extent of your insurance benefits and to get any required authorizations in advance of being seen. These authorizations must be in our office at the time of the visit.***

Co-payments are due at the time of service. A $5.00 Service Charge will be added if you do not pay your Co-Pay at the time of service. If there is any reason copayment cannot be made at the time of service, please notify our staff.

Our billing office will notify you of your insurance coverage for allergy services. However, we cannot guarantee coverage for every service we provide. Some services such as office visits, serums, injections, or testing may not be covered by your insurance. If for any reason your insurance company does not cover treatment, you will be responsible for payment at the time of service. An estimate cost for treatment can be provided upon request.

Acknowledgment of Financial Policy and Assignment of Benefits

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event any claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided. I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator. If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments.

I further agree to be responsible for all charges not covered by my insurance company.

_____ _____

(Patient or Legal Representative signature) **(Date)**

MISSED APPOINTMENT POLICY

In order to provide quality care to our patients, improve, assess, and minimize wait times, our office has adopted the following policy regarding missed appointments.

I understand if I should fail to keep a scheduled appointment three (3) times in twelve (12) consecutive months, it may be necessary for me to make arrangements to receive my medical care elsewhere.

I further understand the policy works as follows:

- A telephone call to cancel the appointment is required at least one (1) business day prior to the scheduled appointment to avoid a missed appointment fee of fifty dollars ($50.00).
- New Patients who fail to keep their scheduled appointment and who do not give a proper notice may not be allowed to reschedule their appointment.
- If one appointment is missed, a reminder letter may be sent indicating that the scheduled appointment has been missed.
- If a second appointment is missed, another letter may be sent.
- Upon failing to keep a third scheduled appointment, a certified letter will be sent indicating your discharge from our care due to missing three (3) scheduled appointments: I further understand that Okemos Allergy Center will care for emergent needs for thirty (30) days from the date of the certified letter. After thirty (30) days, I will need to place my care under another allergist.
- There may be a fee charged for any missed appointment. The current fee for a missed appointment is fifty dollars ($50.00).

Please note: Parent(s) and/or legal guardians will be held responsible for the appointments of minor children/dependents. **The current fee for a missed appointment is fifty dollars ($50.00). Your insurance company will NOT cover this fee. You will not be able to be seen without payment of this fee.**

I have read the above policy in its entirety and fully understand that the above information as it relates to me and to my family members.

Patient Signature: _____

Patient Printed Name: _____

Patient Date of Birth: _____ Today's Date: _____

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

We are required by law to provide a copy of our Privacy Practices.

To acknowledge receipt of this notice, please sign here:

_____ _____

Patient Signature **Date**

Okemos Allergy Center, P.C.

Notice of Privacy Practices Form

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e.name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on their web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

Privacy Notice Continued:

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided in the section "Privacy Complaints".

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services, we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at: Okemos Allergy Center, P.C., 3955 Okemos Rd., Ste.A1, Okemos, MI 48864

We will not retaliate against you for filing a complaint.

Effective Date: 07/08/2013