ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

DEMOGRAPHIC INFORMATION

Please provide your insurance card and driver's license to the front desk. Chart #_____
(office use only)

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
DOB _____ Gender _____ Marital Status _____ Spouse's Name _____
Email Address _____ SSN _____
Occupation _____ Employer _____
Ethnicity (government health care requirement) _____
Emergency Contact _____ Relationship _____
Emergency Contact Phone _____

If patient is a minor (under the age of 18):

Guarantor's Name _____ Address _____
Mother's Name _____ Mother's SSN: _____ Mother's DOB: _____
Father's Name _____ Father's SSN: _____ Father's DOB: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Company Address: _____
Policy #: _____ Group #: _____ Company Phone: _____
Card Holder Name: _____ DOB: _____ SSN: _____
Relationship to Patient: _____ Address: _____
Employer: _____ Employer Phone: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Company Address: _____
Policy #: _____ Group #: _____ Company Phone: _____
Card Holder Name: _____ DOB: _____ SSN: _____
Relationship to Patient: _____ Address: _____
Employer: _____ Employer Phone: _____

PATIENT PAYMENTS: Payment is due at the time of service. There may be a fee for any appointment not canceled 24 hour in advance.

INSURANCE COVERAGE/AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION: We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what insurance plan you are on; please supply us with the correct information at the time of your visit. Some services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some and perhaps all of the services provided may not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered. If you did not update your insurance information at the time of your visit, you will be responsible for a $25.00 refiling fee.

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PROTECTION OF PATIENT PRIVACY: Our clinic policy prohibits video and audio recordings. By signing below, I acknowledge I will not record any interaction on any electronic device in the clinic.

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION: I have been given access to this practice's Notice Regarding Privacy of Personal Health Information, which explains how my medical information will be used and disclosed.

PHOTOGRAPHS: I understand that Allergy & Asthma, PA may use my photograph for treatment and identification purposes.

By signing below, I authorize payment of medical benefits directly to the physician. I authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____

Patient (or Guardian) Signature *Date*

CONTACT INFORMATION

I authorize the Allergy & Asthma Center to call the phone numbers listed below and leave a message on voice mail or give information to persons in reference to my care at this clinic.

Home Phone:_____ Cell Phone: _____
Work Phone:_____ Other Phone: _____

I authorize the clinic to disclose medical information to the persons listed below.

1. Name: _____ Relation: _____
   Home Phone: _____ Cell Phone: _____
2. Name: _____ Relation: _____
   Home Phone: _____ Cell Phone: _____

_____ _____

Patient (or Guardian) Signature *Date*

_____ _____

Patient Printed Name *Date of Birth*

ARE YOU INTERESTED IN RECEIVING INFORMATION OR PARTICIPATING IN CLINICAL TRIALS? Y N

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INSURANCE VERIFICATION

At the ALLERGY & ASTHMA CENTER, PA, we pride ourselves on offering our patients the highest level of professional care and treatment. We also make every effort to communicate expected charges, payments, insurance benefits and coverage. Our staff will contact your insurance company to verify benefits according to clinic policy or at your request if you know there has been a change to your insurance coverage. However, many factors such as pre-existing conditions, non-covered items and individual benefits purchased by the patient or employer affect the amount actually paid.

We urge all patients to personally contact their insurance company to verify their benefits. We cannot guarantee quoted benefits will be what your insurance company pays.

Please ask to speak to one of our Billing staff if you have questions.

_____I have read the above information and **AGREE** to have the recommended tests/procedures performed. I also agree to pay for the service if my insurance does not cover the cost.

_____I have read the above information and **DO NOT AGREE** to have the recommended tests/procedures performed.

_____ _____

Patient (or Guardian) Signature *Date*

_____

Printed Patient Name

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ALLERGY & ASTHMA CENTER FINANCIAL POLICY

Thank you for choosing ALLERGY & ASTHMA CENTER, PA as your healthcare provider. It is our goal to create a pleasant experience for our patients and avoid misunderstandings regarding financial responsibilities. OUR RESPONSIBILITY is to assist you in understanding the provisions and limits of your insurance and to accurately file claims in a timely manner. We will verify benefits, but cannot guarantee that your insurance will pay as quoted.

Please initial each line below to acknowledge your understanding of our financial policy.

_____ Your initial office visit with AAC can range from $75 to $350 depending on the severity of the problem. In addition, if testing is required there will be an additional charge, which could range from $400 to $825 or higher for special testing ordered, depending on your medical condition.

_____ If you have insurance, we will file with your insurance company as a courtesy to you (this does not mean we are taking assignment and only accepting what the insurance company pays). We will send you a statement for the portion your insurance company says you are responsible for. This amount is due upon receipt of your monthly statement. We request that you pay this at the time of service if you know the amount your will not cover (such as you deductible).

_____ YOUR RESPONSIBILITY is to be knowledgeable regarding your benefits, co-pays, deductibles and co-insurance amounts. It is ultimately the patient's responsibility for payment of services provided even if insurance denies the claim or does not pay as expected. Please contact your insurance company directly to verify benefits if you have questions.

_____ YOU are responsible for getting a referral if your insurance requires one. YOU are responsible for the bill if no referral is on file and you choose to be seen without a referral.

_____ You will be asked to provide your insurance card and verify your address and phone number at each visit. If your insurance changes, please notify us immediately as all insurance companies have a timely filing deadline to receive claims.

_____ You will be expected to pay your co-pay or co-insurance at each visit. We will ask for this at the time of check-in. Failure to abide by our contractual agreement subjects us to cancellation of our agreement with the insurance carrier.

_____ SELF-PAY: If you do not have medical insurance, we require the first visit and testing be paid in full at the time of service. Subsequent visits are to be paid in full at the time of service.

Your signature below indicates that you have read, understood, and agree to the policy. A copy is available upon request.

_____ _____

Patient (or Guardian) Signature *Date*

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that ALLERGY & ASTHMA CENTER, PA provided me with a written copy of its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____

Patient Signature *Date*

_____

Personal Representative Signature (if applicable) *Relationship to Patient*

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MEDICAL HISTORY

Name: _____ DOB: _____

Describe the reason or your visit today: _____
How did you hear about our clinic? _____

I. HISTORY OF PRESENT ILLNESS

ALLERGIES: If you have nasal allergies, please indicate your symptoms:

☐ Stuffy nose	☐ Sneezing	☐ Bad breath	☐ Itchy throat
☐ Runny nose	☐ Nosebleeds	☐ Hoarseness	☐ Sore throat
☐ Postnasal drip	☐ Snoring	☐ Itchy eyes	☐ Loss of taste
☐ Throat clearing	☐ Loss of smell	☐ Watery eyes	☐ Headache
☐ Itchy nose	☐ Mouth breathing	☐ Itchy ears	☐ Nasal polyps

Other symptoms: _____
How long have you had allergies? _____ What time of day is worse? _____
Do you have symptoms year round? _____ Which months are worse? _____
Indicate if you have allergy symptoms with the following triggers:

☐ Trees	☐ Cats	☐ Windy days	☐ Alcohol
☐ Grass	☐ Dogs	☐ Cold temps	☐ Spicy foods
☐ Weeds	☐ Feathers	☐ Fragrances	☐ Exercise
☐ Molds	☐ Smoke	☐ Strong odors	☐ Menstrual cycle
☐ Dust	☐ Smog	☐ Chemicals	☐ Stress

Other triggers _____
How often do you have sinus infections? _____
If you have had CT scans of your sinuses, please list the dates _____
If you have had skin testing, please list the dates _____
If you have been on allergy injections, please list the dates _____

ASTHMA: If you have asthma, please indicate your symptoms:

☐ Daytime symptoms	☐ Difficulty getting air in	☐ Chest tightness
☐ Nighttime symptoms	☐ Difficulty getting air out	☐ Wheezing
☐ Shortness of breath	☐ Symptoms with exercise	☐ Cough
	☐	☐

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Name: _____ DOB: _____

Other symptoms: _____
What triggers your asthma symptoms? _____
What time of the year does your asthma worsen? _____
Is your physical activity restricted due to asthma? _____
How often do you use your rescue inhaler? _____
How often have you needed steroids for asthma? _____
Number of missed school/work days due to asthma: _____Number of ER visits for asthma: _____
Number of hospitalizations for asthma: _____Have you ever been intubated? _____
If you have had CT scans of your chest, please list the dates: _____

ECZEMA OR RASHES
Do you have eczema?_____ When did it start? _____
Describe your rash: _____
What medicines have you used for the rash? _____
What soaps and lotions do you use? _____
Have you had a biopsy? If yes, when? _____

HIVES OR SWELLING
Do you have hives or swelling?_____ When did it start? _____
Describe your symptoms: _____
What have you used for the symptoms? _____
Have you had a biopsy? If yes, when? _____

OTHER ALLERGIES
Do you have a food allergy? _____
If yes, list the foods and reactions: _____
Do you continue to eat these foods? _____
Have you had a life threatening reaction to an insect sting? _____
If yes, please list the insects and reactions: _____

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Name: _____ DOB: _____

II. PAST MEDICAL HISTORY

Please indicate if you have been diagnosed with the following conditions:

☐ Heart disease	☐ Diabetes	☐ Hypertension	☐ Depression
☐ Sleep apnea	☐ Cataracts	☐ High cholesterol	☐ Anxiety
☐ Pneumonia	☐ Glaucoma	☐ Thyroid disease	☐ Cancer
☐ COPD	☐ Reflux disease	☐ ADHD	☐ HIV/AIDS

Other medical conditions _____

If you have had the following surgeries, please list the dates:

Sinus surgery _____ Tonsillectomy _____ Adenoidectomy _____ Ear tubes _____

Other surgeries: _____

List the dates for the following vaccines: Influenza _____Pneumococcal ("Pneumonia") _____

List all your current medications including vitamins and supplements:

Medication	Dosage	Frequency	Reason for taking medication

Name & Telephone Number of your pharmacy. _____

Do you have an epinephrine autoinjector? _____

List any medication allergies and reactions: _____

Are you allergic to latex? _____ If yes, what are your symptoms? _____

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Name: _____ DOB: _____

III. SOCIAL HISTORY

Occupation _____ Who lives at home with you? _____
Marital status _____ If you have children, please list their ages: _____
Do you currently smoke? _____ If yes, # of cigarettes per day _____ For how long? _____
_____
Did you smoke in the past? _____ If yes, # of cigarettes per day _____ For how long? _____
_____
When did you quit? _____
Is there anyone in your home that smokes? _____ If yes, do they smoke indoors or outdoors? _____
Do you drink alcohol? _____ If yes, how often? _____
Do you use illicit drugs? _____ If yes, what kind and how often? _____
If you exercise, what type and how often? _____
List your hobbies: _____

ENVIRONMENTAL HISTORY

Do you have pets? _____ What kind and how many? _____
Do the pets live indoors or outdoors? _____ Do they sleep in the bedroom? _____
How old is your home? _____
What types of plants are around your home? _____
How long have you lived in Central Texas? _____
Where did you live prior to Central Texas? _____

IV. CHILDREN UNDER 12 YEARS OLD

Were there any complications during pregnancy or childbirth? _____
Does your child go to day care? _____ What grade is the child in? _____
If the child has siblings, please list their ages: _____
Has the child has RSV infection in the past? _____

V. FAMILY HISTORY

If anyone in your family has been diagnosed with the following conditions, please specify the relation:

Asthma _____ Food allergy _____ Hives _____
Hay fever _____ Eczema _____ Other _____
Father's age: _____ If deceased, age and cause of death: _____
Mother's age: _____ If deceased, age and cause of death: _____

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Name: _____ DOB: _____

VI. REVIEW OF SYSTEMS

Indicate if you have the following symptoms:

☐ Fever	☐ Weight gain	☐ Abdominal pain	☐ Visual changes
☐ Chills	☐ Weight loss	☐ Urinary infections	☐ Dizziness
☐ Fatigue	☐ Cold intolerance	☐ Blood in stool	☐ Fainting
☐ Chest pain	☐ Heat intolerance	☐ Insomnia	☐ Muscle pain
☐ Palpitations	☐ Nausea	☐ Anxiety	☐ Joint pain
☐ Leg swelling	☐ Vomiting	☐ Memory loss	

Are any of your family members treated at this clinic? If yes, please list _____

_____

Please provide any other information you think may be helpful in assisting in your care: _____

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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ALLERGY SKIN TESTING

To prepare for your allergy skin test, please do not take any antihistamines or medications that contain antihistamines for five (5) days before your appointment (common antihistamines listed below). Please continue all your asthma medications. If you have questions regarding other medications you are taking, please call our office and check with the nursing staff.

Any non-barbituate sedative	Compazine	Meclazine	Robitussin Nighttime
with the name "PM", "sleep	Compoz	Medi-flu	Rondec Syrup
aid" or "nighttime"	Comtrex	Methscopolamine	Ru-Tuss
Acrivastine	Contac/Ornade	Midol	Ryna-C
Actifed	Contac Severe Cold & Flu	Mizolastine	Rynatan
Adapin	Coricidin	Naldecone	Rynatuss
Alavert (loratadine)	Cotab AX, Cotab Flu	Naphcon-A eye drops	Scot-Tussin
Alfen DMA	CoTylenol Cold Forumla	Nolahist	Semprex, Semprex D
Alka-Selzer Plus Cold & Cough	Cyproheptadine	Nolamine	Sine-Off
Allegra, Allegra-D	Dallergy	Norel DM, Norel SR, Norel LA	Sinubid
Aller-Chlor	Deconamine SR	Novafed-A	Sinulin
Allerhist	Desloratadine	Novahistine DH liquid	Sinutab
Allerest	Dexbrompheniramine	Nytol	Sominex
AlleRx	Diphedryl	Nyquil Multi-Symptom	Sudafed Plus
Antivert	Diphen	Nyquil Nighttime Cold	Sudal-12
Astelin Nasal Spray	Diphenhydramine	Opcon-A eye drops	Tagamet
Astemizole	Dimetane	Optimine	Tanafed
Astepro Nasal Spray	Dimetapp	Optivar eye drops	Tavist-1
Atarax	Doxepin	Ornade	Tavist-D
Atrohist	Dramamine	Orthoxicol	Theraflu Flu, Cold & Cough
Axid	Dristan	Palgic	Theraflu Maximum Strength
Azatadine	Drixoral	Pamprin	Thorazine
Azelastine	Drixoral Cold & Flu	Pataday eye drops	Trinalin
Benadryl (diphendyramine)	Drixoral Cold & Allergy	Patanase nasal spray	Triprolidine
Benylin	Duratuss	Patanol eye drops	Triaminic Nighttime
Bepreve eye drops	Dura-Vent	PBZ	Triaminicin
Brexin	Dymista Nasal Spray	Pediox-S	Tussend
Bromfed	Elestat eye drops	Pepcid	Tussionex
Brompheniramine	Emadine eye drops	Periactin	Tylenol PM
Brovex	Extendryl	Phenergan	Tylenol Allergy, Cold & Flu
Calm-Aid	Fedahist	Phenindamine	Unisom
Carboxinoxamine	Fexofenadine	Phenyltoloxamine	VasoBid, VazoTan
Cerose DM	4 Way Cold	Polarmine	Vicks 44 Cough, Cold & Flu

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Cetirizine	Genahist	Polyhistine-D	Vistaril
Cheracol-Plus	Hycomine	Poly-DM Syrup	Visine-A eye drops
Cheracol-Sinus	Hydramine	Premysn	Zaditor eye drops
Chlo-Amine	Hydroxyzine	Promethazine	Zantac
Clarinex, Clarinex-D	Isochlor	Pyrilamine	Zyrtec, Zyrtec-D
Claritin, Claritin-D (loratadine)	Kronafed	Pyrroxate	Xyzal
Chlorafed	Livostin	Pyrlex, Pyrlex PD	Zymine HC, Zymine-D
Chlorpromazine	Lodrane, Lodrane D	Quelidrine	Zymine liquir
Chlor-Trimeton	Loratadine	Ranitidine	
Chlorpheniramine	Maxichlor PSE DM	Rescon	
Codimal	Maxiphen ADT	Rezine	

****** Diurectic medications (such as Lasix) and antidepressants should only be stopped the day prior to your visit. ******

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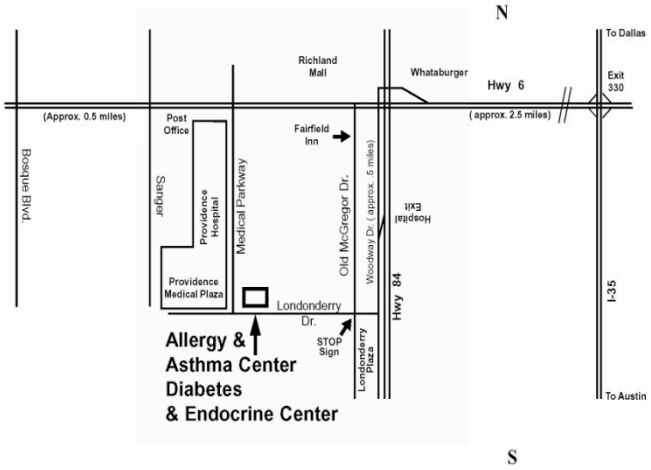
DIRECTIONS TO ALLERGY & ASTHMA CENTER



FROM US 84 (TRAVELING EAST)

- Exit Sante Fe/Texas Central Parkway (stay in the left lane).
- Turn LEFT at the stoplight onto Sante Fe and proceed through next stoplight.
- At the four-way stop, turn RIGHT onto Old McGregor Road. Stay on this street for 0.3 miles.
- At second four-way stop, turn LEFT onto Londonderry Drive. Travel 0.2 miles.
- Office is on the right, just before Providence Hospital.

FROM HWY 6

- Take Sanger Avenue exit.
- Stay on the access road. Travel past the Post Office.
- Turn RIGHT onto Medical Parkway.
- Our office is on the left corner of Medical Parkway and Londonderry Drive.

FROM US 84 (TRAVELING WEST)

- Take Londonderry Drive exit.
- Turn RIGHT onto Londonderry Drive. Travel 0.3 miles.
- Our office is on the right, just before Providence Hospital.

FROM I-35

- Exit TX-6 North/Meridian (Exit 330).
- Follow curve to merge onto TX-6/TX Loop 340.
- Travel on TX-6 for 2.5 miles.
- Take exit on to US 84/Waco Drive.
- Stay in the middle lane; proceed through first stoplight.
- Turn LEFT at second light; go under TX-6 overpass.
- Go straight through next light. Travel 0.5 miles to Londonderry Drive.
- Turn RIGHT onto Londonderry Drive. Travel 0.3 miles.
- Office is on the right, just before Providence Hospital.

SATELLITE CLINICS

MEXIA
514 S. Bonham, Suite D
Mexia, TX 76667

HILLSBORO
1323 E. Franklin, Suite 103
Hillsboro, TX 76645

GATESVILLE
1507 W. Main Street
Gatesville, TX 76528

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NOTICE OF PRIVACY PRACTICES

Effective Date: September 1, 2013

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.

If you have any questions about this Notice, please contact: JERRY GERSBACH at (254) 751-1144, ext. 390

WHO WILL FOLLOW THIS NOTICE?

- ✓ Niran J. Amar, M.D.
- ✓ Ephraim Thaller, M.D.
- ✓ Neil Amar, M.D.
- ✓ All ALLERGY & ASTHMA CENTER, PA employees

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive care at ALLERGY & ASTHMA CENTER, PA a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES:

ALLERGY & ASTHMA CENTER, PA shall:

- Make every effort to maintain the privacy of your medical information;

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- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

ALLERGY & ASTHMA CENTER, PA will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment:** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment:** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations:** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run ALLERGY & ASTHMA CENTER, PA in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders:** We may use and disclose medical information in order to remind you of an appointment. For example, ALLERGY & ASTHMA CENTER, PA may provide a written or telephone reminder that your next appointment with ALLERGY & ASTHMA CENTER, PA is coming up.
- **Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your

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specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

- **As Required by Law:** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice:** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS

- **Organ and Tissue Donation**: If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel:** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks:** We may disclose medical information about you for public health activities. These activities generally include the following activities:

  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - 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; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

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- **Lawsuits and Disputes:** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If ALLERGY & ASTHMA CENTER, PA determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors:** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates**: If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures:** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for ALLERGY & ASTHMA CENTER, PA. If you request a copy of the information, ALLERGY & ASTHMA CENTER, PA may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

  ALLERGY & ASTHMA CENTER, PA may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by ALLERGY & ASTHMA CENTER, PA will review your request and denial. The person conducting the review will not be the person who denied your request. ALLERGY & ASTHMA CENTER, PA will comply with the outcome of the review.

- **Right to Amend:** If you feel that medical information maintained about you is incorrect or incomplete, you may ask ALLERGY & ASTHMA CENTER, PA to amend the information. You have the right to request an amendment for as long as the information is kept by ALLERGY & ASTHMA CENTER, PA.

  To request an amendment, your request must be made in writing and submitted to ALLERGY & ASTHMA CENTER, PA. In addition, you must provide a reason that supports your request.

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ALLERGY & ASTHMA CENTER, PA may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, ALLERGY & ASTHMA CENTER, PA may deny your request if you ask us to amend information that:

- Was not created by ALLERGY & ASTHMA CENTER, PA, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by ALLERGY & ASTHMA CENTER, PA;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list you must submit your request in writing to **Jerry Gersbach** (Administrator). Your request must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. ALLERGY & ASTHMA CENTER, PA will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information ALLERGY & ASTHMA CENTER, PA uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information ALLERGY & ASTHMA CENTER, PA discloses about you to someone who is involved in your care or the payment for your care.

  ALLERGY & ASTHMA CENTER, PA is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which ALLERGY & ASTHMA CENTER, PA has been paid out of pocket in full. Should ALLERGY & ASTHMA CENTER, PA agree to your request, ALLERGY & ASTHMA CENTER, PA will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions you must make your request in writing to ALLERGY & ASTHMA CENTER, PA. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit ALLERGY & ASTHMA CENTER, PA's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications:** You have the right to request that ALLERGY & ASTHMA CENTER, PA communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that ALLERGY & ASTHMA CENTER, PA contact you only at work or by mail.

  To request that ALLERGY & ASTHMA CENTER, PA communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. ALLERGY & ASTHMA CENTER, PA will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE

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ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with ALLERGY & ASTHMA CENTER, PA or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with ALLERGY & ASTHMA CENTER, PA, contact the Privacy Officer at 254-751-1144, ext #390. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

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