OAC
OKEMOS ALLERGY CENTER

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

Welcome to our office. Enclosed, please find your registration materials and please complete all sections prior to your arrival.

Important: Please review the medication information sheet on the next page at least five (5) days prior to your appointment. The medications listed may interfere with allergy testing and failure to stop the medications may lead to the necessity of rescheduling your appointment. If you have any questions about the list, please call our office.

If your initial appointment is to include skin testing, please allow roughly two (2) hours for the appointment.

If your appointment is for Penicillin testing, please allow roughly three (3) hours for the appointment.

If your insurance requires a co-pay, we will collect that at the time of service. Allergy testing costs will vary depending on the number of items you're being tested for. These costs are determined by what your insurance and specific plan will cover. Deductible (out-of-pocket costs) are determined by your insurance.

We strongly suggest you review your coverage details with your insurance company by calling the customer service number which is on the back of your insurance card. It is your responsibility to know your insurance plan and coverage details. We as an office do not have the level of access you have with your insurance company.

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

Regards,

Manoj Mohan, D.O.
Jessica Baird, DNP, FNP-BC
Lawrence Hennessey, M.D., Retired
Kamal Mohan, M.D., Founder, Retired

Important Medication Information for Allergy Testing.
Medications can interfere with allergy skin testing. The following medications need to be stopped the specified number of days prior to your visit.

DO NOT STOP TAKING YOUR ASTHMA MEDICATIONS

STOP DAYS		STOP DAYS		STOP DAYS	
2	Actifed	5	Clemastine (RX)	2	Nizatidine
2	Advil-PM	3	Compazine	2	Nyquil
5	Alavert	2	Contac	2	Olopatadine (nasal)
5	Allegra (180 mg)	5	CyClobenzaprine	2	Pataday
2	Allegra (30 mg, 60 mg)	5	CyProheptadine	2	Patanase
2	Allegra-D (12-Hour)	6	Desloratadine	2	Pepcid
5	Allegra-D (24-hour)	5	Dexchlorpheniramine	5	Periactin
3	Antivert	3	Dimenhydrinate	3	Phenergan
5	Arbinoxa	2	Dimetane	3	Prochlorperazine
2	Astelin	2	Dimetapp	3	Promethazine
5	Atarax	2	Diphenhydramine	2	Sominex
2	Axid	3	Dramamine	2	Tagamet
2	Azelastine	2	Dymista	5	Tavist (non-drowsy)
2	Benadryl	2	Excedrin-PM	2	Tavist (OTC)
2	Bromfed	2	Famotidine	5	Tavist (RX)
2	Brompheniramine	5	Fexofenadine (180 mg)	3	Tigan
5	Carbinoxamine	2	Fexofenadine (low-dose)	3	Trimethobenzamide
5	Cetirizine	5	Flexeril	2	Triprolidine
2	Chlorpheniramine	2	Histex	2	Tums Ultra
2	Chlor-Trimeton	5	Hydroxyzine	2	Tylenol-PM
2	Cimetidine	5	Karbinal	5	Vistaril
6	Clarinex	2	Kronofed	5	Xyzal
6	Clarinex-D	5	Levocetirizine	2	Z-Quil
5	Claritin	5	Loratadine products	5	Zyrtec
2	Clemastine (OTC)	3	Meclizine	5	Zyrtec-D
2	Actifed	5	Clemastine (RX)	2	Nizatidine
2	Advil-PM	3	Compazine	2	Nyquil

- **DECONGESTANTS:** Stop taking only when combined with antihistamines.
- **ANTACIDS:** You can continue taking: *Prevacid, *Prilosec, *Nexium and other “PPI” drugs (*lansoprazole, *omeprazole, etc).

PATIENT REGISTRATION FORM

Personal Information

Please check here if you are a former patient: _____

Patient's Legal Name: _____ Preferred Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home/Cell Phone: _____

Email Address: _____

Date of Birth: _____ Birth Sex: _____ Male _____Female

Gender Identity: _____ Male _____ Female _____ Chosen gender identifier

Preferred Pronoun(s): _____ 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 _____ Text
_____ No Preference

Primary/Pediatrician Physician's Full Name: _____

Referring Physician: _____

In Case of Emergency Notify: _____

Relationship to Patient: _____

Phone: _____

If the patient is a minor or dependent, please provide the following parent/guardian information:

Primary's Legal Name: _____

Primary's Date of Birth: _____

Home/Cell Phone: _____

Secondary's Legal Name: _____

Secondary's Date of Birth: _____

Home/Cell Phone: _____

Address (if different from patient):

_____

_____

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

(Please Present All Insurance Cards to Staff)

Primary Insurance: _____

Subscriber's Name: _____

Relationship to Patient: _____

Date of Birth: _____

Contract No. _____ Group No. _____

Co-pay Amount (if any) $_____

Secondary Insurance (if any): _____

Subscriber's Name: _____

Relationship to Patient: _____

Date of Birth: _____

Contract No. _____ Group No. _____

Co-pay Amount (if any) $_____

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.***

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, <u>you will be responsible for payment at the time of service</u>. 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)**

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

To acknowledge receipt of this notice, please sign here:

_____ _____

Patient/Parent 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.

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