Illinois Allergy & Asthma Specialists

Drs. Amishi Singal Murthy and Vivian Chou
500 Davis St • Suite 512 • Evanston, IL 60201
3000 N Halsted St • Suite 724 • Chicago, IL 60657
Phone (847) 328-7909 • Fax (847) 328-7919
www.ilallergyasthma.com

New Patient Registration Form

Date: _____ Patient Name: _____ Date of Birth: _____

Preferred Name: _____ Sex assigned at birth: _____ Gender Identity: _____

Gender pronoun: _____ Social Security Number: _____ Civil Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Primary: (____) ____-____ Secondary: (____) ____-____ Tertiary: ( ) ____-____ Preferred: _____

OK to leave message regarding normal test results on voice mail? Please check one: Yes No

Email Address: _____

*Please refer to Enrollment in Online Patient Health Record Access and Email Communication Authorization for details. If minor,

name of parent/guarantor: _____ Relation: _____

Emergency contact:

Name: _____ Relationship to patient: _____ Phone: (__) ____-____

Preferred pharmacy: _____ Phone: (____) ____-____

Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone: (____) ____-____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: (____) ____-____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY Insurance:

Insurance Company: _____ Subscriber ID #: _____ Group #: _____

Billing Address (if different from above): _____ City: _____ State: _____ Zip: _____

Insured's name: _____ Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____ Employer's phone: (_____) _____-_____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Co-Pay amount: $_____

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SECONDARY Insurance (if applicable):

Insurance Company: _____ Subscriber ID #: _____ Group #: _____

Billing Address (if different from above): _____ City: _____State: _____ Zip: _____

Insured's name: _____ Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____ Employer's phone: (_____) _____-_____

Employer's Address: _____City: _____ State: _____ Zip: _____

Co-Pay amount: $_____

Authorization for Medical Care, Payment and Release of Information

I, the undersigned, hereby authorize the physicians of Illinois Allergy and Asthma Specialists, SC to render medical evaluation and treatment for the named patient. I authorize payment of medical benefits for any services furnished to me or to the patient by Illinois Allergy and Asthma Specialists, SC. I understand that I am responsible for any amount not covered by my insurance (i.e. plan exclusion, no referral on file, out of network, coverage terminated, high deductible, etc.). I authorize Illinois Allergy and Asthma Specialists, SC to release any information acquired in the course of my evaluation or treatment to any provider, other party, or my insurance company or their agent for the purpose of treatment, payment, or practice operations.

Cancellation and Delinquent Account Policy

To best service the schedules of our patients: for office visits canceled less than 24 hours in advance, or failure to keep an appointment, patients may incur a $50 charge. All accounts not paid within 60 days will be forwarded to a collection agency.

Signature: _____ Date: _____

Printed Name: _____ Patient's Name: _____

Credit Card type: Visa MasterCard AMEX (online payment only) Discover (online payment only) Credit Card

Number: _____

Expiration Date: _____ Security Code: _____

I hereby acknowledge receipt of the medical services, authorize IAAS to bill the above credit card for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in your agreement with the credit card issuer.

I authorize IAAS to process the above credit card as "card on file." I will be notified when my credit card is charged. I understand this authorization will remain in effect until the expiration of the credit card account. Patient also may revoke this form by submitting a written request to the medical practice. I have read and understand the financial policy of this medical office and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without prior written notice.

_____ Initial

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Illinois Allergy and Asthma Specialists ("the practice") may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Illinois Allergy and Asthma Specialists reserves the right to revise its Notice of Privacy Practices at any time. I also understand that a copy of any Revised Notice will be provided to me or made available online at www.ilallergyasthma.com**. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.**

With my consent, and in accordance with Illinois law, Illinois Allergy and Asthma Specialists:

- May call my home/cell phone and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including test results among others.
- Mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements and reminders to have labs drawn.
- Use email to communicate any items that assist the practice in carrying out TPO, such as patient statements and lab requisitions.
- Send email, SMS or text messages to my mobile device any items that assist the practice in carrying out TPO, such as appointment reminders and lab reminders and documents related to patient registration/appointment information.
- **Please note: Lab/testing results will ONLY be sent via **SECURE** messaging.
- Regarding email communication, please note:
- Email should be used for NON-EMERGENCY purposes only.
- Your doctor may not be checking email frequently and may take 48-72 hours to respond to your emails.
- Emails will not be answered over the weekends, holidays, or after business hours. Regular business hours are from 9 am to 5 pm, Monday through Friday.
- For any emergencies, please call 911.
- For any urgent issues, please call the office at 847-328-7909.
- Email communications from your physician may NOT be encrypted, and the security of such emails cannot be guaranteed.
- All email communications and pictures will be filed in your or your child's permanent medical record.
- Please inform this office in writing if you change your email address.

I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO, and I understand I may contact the office to opt out of e-mail or SMS or text communications. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I consent to the practice's use and disclosure of my PHI to carry out TPO as well as use of email.

Current email address: _____

Printed name of patient: _____

Signature of patient/parent/guardian: _____ Date: _____

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Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Illinois Allergy and Asthma Specialists to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____(Patient's Name).

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available online at www.ilallergyasthma.com

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Communication with Family Members/Parents/Others:

We take patient confidentiality very seriously. In addition to yourself or your child, please specify another person(s) with whom we may discuss your test results/health information, if so desired

◯ I want my test results/healthcare information reported only to me

◯ Dr. Chou and Dr. Murthy have my permission to speak with the following individuals only (Please include name/relationship and telephone number):

1. _____

2. _____

3. _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____