

KERN ALLERGY MEDICAL CLINIC, INC

Tonny Tanus, M.D. Eric J Boren, M.D

New Patient Information

Please Print

Patient's Name: \_\_\_\_\_ SS# \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M \_\_\_\_\_ F \_\_\_\_\_ Marital Status: M \_\_\_\_\_ S \_\_\_\_\_ W \_\_\_\_\_ D \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone#(\_\_\_\_) \_\_\_\_\_ Work#(\_\_\_\_) \_\_\_\_\_ Cell#(\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ Pharmacy \_\_\_\_\_

Language: \_\_\_\_\_ Race:  Caucasian  African American  Hispanic  Asian  Other \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Non-Hispanic or Latino  Other or Undetermined

Guarantor's Name: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(If not Patient)

Place of Employment: \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address of Insured: \_\_\_\_\_

Home Phone#(\_\_\_\_) \_\_\_\_\_ Work#(\_\_\_\_) \_\_\_\_\_ Cell#(\_\_\_\_) \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address of Insured: \_\_\_\_\_

Home Phone#(\_\_\_\_) \_\_\_\_\_ Work#(\_\_\_\_) \_\_\_\_\_ Cell#(\_\_\_\_) \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

**OFFICE POLICY:**

1. Medical care will not be provided over the phone. Lab or procedure results and antibiotic requests will be discussed at office visits only unless previously arranged with the doctors.
2. No medications will be refilled on weekends or holidays. The office answering service will be used for emergencies only when you cannot wait until the next business day. Go to an ER or call 911 immediately for any severe allergic reactions or asthma exacerbations.

\_\_\_\_\_  
Member or Member's Legal Guardian ( Print )

\_\_\_\_\_  
Member or Member's Legal Guardian (Sign)

\_\_\_\_\_  
Date



Tonny Tanus, MD  
Eric J. Boren, MD  
Darryl Altavas, FNP  
*Board Certified Adult & Pediatric*

[www.kernallergy.com](http://www.kernallergy.com)

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FAX: 782-8594

1402 Jefferson St.  
Delano, CA 93215  
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**KERN ALLERGY MEDICAL CLINIC, INC. FINANCIAL/OFFICE POLICY:**

Our goal is to provide outstanding allergy care for our patients as well as foster good physician/staff-patient relationships. Please do not hesitate to ask a staff member if you have any questions.

1. I understand that it is my responsibility to provide my correct and current insurance information. Otherwise I will be liable for any and all charges.
2. I am responsible for all Co-payments, Deductible, and Co-insurance due at the time of service.
3. It is my responsibility to understand my insurance benefit plan. It is my responsibility to know if a written referral or authorization is required for office visits and procedures.
4. Not all services provided by our office are covered by all insurance plans. Any service determined to not be covered by my plan will be my responsibility.
5. If our physicians do not participate in your health plan, payment is expected in full at the time of service.
6. We require that a current copy of your personal credit card or the health savings account debit/credit card remains on file. Our software has been thoroughly vetted according to strict data retention rules and is HIPPA compliant.
7. Patient balances are billed after we receive your insurance plans explanation of benefits (EOB) with your balance owed. Your payment is due within 30 days from the date on your statement. If you do not pay your balance within 60 days, we will automatically charge your personal credit card on file for the amount due.
8. A \$50 fee will be charged for any checks returned, plus any bank fees incurred.
9. For medical records there will be a fee of \$15.00 for one report and \$35.00 for complete chart. This fee is due at the time of request.
10. If you or your child has forms to be completed by your physicians, there will be a charge of \$15 per page. Payment is due when the forms are dropped off. We typically have a 3-5 business day turnaround time.

**Initial** \_\_\_\_\_

Continue on back side.....

**TERMS AND CONDITIONS**

I agree to pay Kern Allergy Medical Clinic, Inc. for all charges incurred, which are not promptly reimbursed by the insurer. As any direct billing by Kern Allergy Medical Clinic, Inc. to the insurance company is merely an accommodation, I will be primarily and ultimately responsible for payment.

If my account goes over 60 days, I agree to have my credit card charged to pay any balance on my account that is over 60 days. After credit card number is entered, the number will be blacked except for the last 4 digits.

\_\_\_\_ Visa    \_\_\_\_ MasterCard    \_\_\_\_ American Express    Account # \_\_\_\_\_

Security Code (3 digit code) \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name of Card Holder \_\_\_\_\_

If this account is assigned to an attorney for collection and/or suit the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I further consent to and direct my insurance carrier, third party liability carrier, employer, or any person possessing pertinent information to release such information upon demand. A copy of this authorization shall serve as on original. I, on behalf of the patient and/or individual, accept and agree to these terms and conditions.

I have read and understand this office financial policy and agree to comply and accept the responsibility of any payment that becomes due as outlined.

**Patient Name(s):** \_\_\_\_\_

Responsible party (guarantor) name if different and relationship:

\_\_\_\_\_

**Responsible Party/Patient Signature:**

\_\_\_\_\_

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



## APPOINTMENT POLICY

I understand that this is the appointment policy for the office of Kern Allergy Medical Clinic.

- I will be charged:**
- \$30 fee for any missed No-Show appointments
  - \$50 fee for any missed procedure appointment (Testing or Pulmonary Function Test)

To avoid a fee; appointments need to be cancelled within **24 hours** of my scheduled time. If I have two appointments scheduled on the same day I am subject to a \$30 fee and a \$50 fee for both appointments for a total of \$80.00. We do understand emergencies, illness, etc. If you are not able to call the office that day please call us as soon as you are able to.

***The fee is due before your next scheduled appointment. If you have two No-Show fees totaling \$60max it must be paid before another appointment can be scheduled.***

I am aware I can leave a detailed message on our after-hours answering service if I am not able to keep my appointment. Please make sure to leave patients name, D.O.B, appointment time, and reason for your cancellation. Our Receptionist will check messages each business day. Failure of not leaving a message will result in a No-Show fee. Otherwise, we assume the appointment will be kept with your physician.

Keep in mind it is a courtesy call to remind you of your appointment. It is ultimately your responsibility to write down and keep track of your appointments.

These fees are your responsibility and not payable by your insurance company. Also patients that have multiple no shows and cancellations may be dismissed from the practice.

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Print Patient/Guardian Name

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Patient/Guardian Signature

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Date



Patient Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

### Health History

Please check  all conditions you **currently** have or have had in the **past**.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Colon Cancer           | <input type="checkbox"/> Hashimoto's Thyroiditis |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> High cholesterol        |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Cohn's Disease         | <input type="checkbox"/> Hypothyroidism          |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Depression             | <input type="checkbox"/> Hypertension            |
| <input type="checkbox"/> Blood Transfusions  | <input type="checkbox"/> Diabetes- Type 1       | <input type="checkbox"/> Hypertension            |
| <input type="checkbox"/> Brain Tumor         | <input type="checkbox"/> Diabetes- Type 2       | <input type="checkbox"/> Hepatitis A             |
| <input type="checkbox"/> Bipolar Disorder    | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Hepatitis B             |
| <input type="checkbox"/> Cirrhosis           | <input type="checkbox"/> Fibromyalgia           | <input type="checkbox"/> Hepatitis C             |
| <input type="checkbox"/> COPD                | <input type="checkbox"/> GERD / Acid Reflux     | <input type="checkbox"/> HIV / Aids              |
| <input type="checkbox"/> Other: _____        |   |  |

### Family History

Please check  any medical conditions that First Degree relatives have (e.g., Mother, Father, siblings)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Angina             |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Cervical Cancer    |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Growth/Development |
| <input type="checkbox"/> Birth defects        | <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Headaches          |
| <input type="checkbox"/> Bleeding disease     | <input type="checkbox"/> Lung/Respiratory disease | <input type="checkbox"/> Lung Cancer        |
| <input type="checkbox"/> Breast Cancer        | <input type="checkbox"/> Migraines                | <input type="checkbox"/> Melanoma           |
| <input type="checkbox"/> Bipolar Disorder     | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Ovarian cancer     |
| <input type="checkbox"/> Crohn's Disease      | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Psychiatric Cancer |
| <input type="checkbox"/> Colon cancer         | <input type="checkbox"/> Severe allergies         | <input type="checkbox"/> Uterine Cancer     |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Weight disorder    |
| <input type="checkbox"/> Diabetes Type 1 or 2 | <input type="checkbox"/> Thyroid problems         | <input type="checkbox"/> MS                 |
|   |   | <input type="checkbox"/> Endometriosis      |
|   |   | <input type="checkbox"/> Other: _____       |

For any of the above conditions checked, please state the relationship:

If you are 13 years of age and older please answer the following question. Parents please answer this question for any smokers in the home for minors.

Tobacco Use:  Never  Former Smoker/ Quit \_\_\_\_\_  Yes #cigs \_\_\_\_\_/day  
Alcohol Use:  Never  occasionally  yes - amount per day \_\_\_\_\_

1. List any over-the-counter and prescribed medications you are currently taking:

Name:	Dose:

2. Please List any surgeries or hospitalizations you have had:


3. What do you have in your home? Check all that apply

Please state whether pet(s) are *indoor* or *outdoor*

- Dog(s)
- Cat(s)
- Cattle
- Rabbits
- Horse(s)
- Other \_\_\_\_\_
- Tile
- Carpet
- Linoleum
- Laminate
- Wood
- A/C
- Swamp Cooler

4. Please list any allergies to medication:


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The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information, for payment or health care operations, in order to provide health care.

We also want you to know that we support your full access to your personal medical records. Written consent will be needed, and your doctors review. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we may have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review privacy notice, to request restrictions and revoke consent in writing, after you have reviewed our privacy notice.

**COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS**

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability act (HIPPA) with the particular emphasis on the "Privacy Rule".

It is our policy to properly determined appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of the plan, we have implemented a Compliance Program that will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of the fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event is any way compromises our Policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent, Guardian, (if patient is under 18yrs) or Patients

As a courtesy our office may confirm your appointment by telephone if you approve. Can we confirm your appointment, and use Kern Allergy name? Please indicate YES \_\_\_\_\_ or NO \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent, Guardian, (if patient is under 18yrs) or Patients