Kern Allergy Medical Clinic, INC
Tonny Tanus, M.D. Eric J Boren, M.D.
Darryl Altavas, FNP
New Patient Information

Please Print Clearly

PATIENT First Name_____ **Middle Initial** ____ **Last Name**_____ **Gender**_____ **Date of birth** ___/___/_____

Marital Status: M___**S**___**W**___**D**___ **Race:** _____ **Ethnicity:** _____

Social Security # _____-_____-_____ **** Required or Credit Card will be ask to be kept on file for billing purposes****

Language_____ **Home Phone #**_____-_____-_____ **Cell phone**_____-_____-_____ **Preferred Phone (Circle): Home / Cell**

Home Address_____ **City**_____ **State**_____ **Zip Code**_____

Email Address_____ **Primary Physician:** _____ **Referring Physician:** _____

Preferred Pharmacy_____ **Cross Street**_____

Insurance

Primary Insurance _____

Policy #: _____ **Group #:** _____

Subscriber Name: _____ **DOB:** ____/_____/_____

Social Security _____-_____-_____ **Relationship to patient:** _____

Secondary Insurance: _____

Policy #: _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____/____/_____

Social Security _____-_____-_____ **Relationship to patient** _____

Please complete if patient is a minor/student

Mother (Or Guardian) Information If Legal Guardian, relationship to patient_____

First Name_____ Middle initial_____ Last Name_____

SS#_____ Date of birth___/___/_____ Home Phone # _____ Cell Phone #_____

Home Address_____ City_____ State_____ Zip code_____

Employer_____ Occupation_____ Work Ph #_____

Father (Or Guardian) Information If Legal Guardian, relationship to patient_____

First Name_____ Middle initial_____ Last Name_____

SS#_____ Date of birth___/___/_____ Home Phone # _____ Cell Phone #_____

Home Address_____ City_____ State_____ Zip code_____

Employer_____ Occupation_____ Work Ph #_____

HIPPA contacts: Authorization to Release Protected Health Information to the following individuals

Name: _____ Phone # _____-_____-_____ Relationship_____ _____

Name: _____ Phone # _____-_____-_____ Relationship_____ _____

Name: _____ Phone # _____-_____-_____ Relationship_____ _____

_____ _____

Signature of Patient or Parent/Guardian/Responsible Party Date

KERN ALLERGY MEDICAL CLINIC

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

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 provides 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 18 yrs of age) (Parent, Guardian, if patient is under 18 yrs of age)

KERN ALLERGY MEDICAL CLINIC, INC.

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 (Skin 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 results 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.

_____

Print Patient/Guardian Name

_____ _____

Patient/Guardian Signature Date

EB 01/18

Kern Allergy Medical Clinic

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Board Certified Adult & Pediatric

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FAX: 721-8319

KERN ALLERGY MEDICAL CLINIC 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.

Insurance Coverage:

- As a courtesy Kern Allergy will verify your coverage and bill your insurance carrier on your behalf. However, **you are ultimately financially responsible for the payment of your bill.**
- It is your responsibility to be aware of your insurance eligibility and coverage including but not limited to:
  - Copay amounts
  - Applicable coinsurance amounts
  - Deductible amount
  - Authorization requirements
  - Exclusions
  - Limitations
  - Policy previsions

Please refer to your summary of benefits from your insurance carrier or contact your insurance carrier directly if you have any questions regarding your coverage.

- Kern Allergy will attempt to verify that your coverage is valid at the time of your visit(s) however, if your coverage is not in effect at the time of your visit(s), th**e financial responsibility is yours.**
- Kern Allergy will make every effort to determine the amount of applicable copayment, co-insurance or deductible that you owe prior to your appointment based on the information available from your insurance carrier.
- **YOU ARE FINANCIALLY RESPONSIBLE FOR PAYING ALL COPAYMENTS, CO-INSURANCE AND DEDUCTIBLES DUE AT THE TIME OF SERVICE.** After your insurance carrier processes a claim, if they determine that you have a greater financial responsibility, you will receive a bill in 30 days of receipt. If your insurance carrier determines that you owe less, any overpayment will be refunded.
- You are responsible to provide correct and current insurance information, including eligibility. Otherwise you are financially responsible for payment of any claims affected.
- You are responsible for responding to any request from your insurance carrier for additional information. Not responding to these requests in the claim(s) being denied and you will be financially responsible for payment of any claims affected.

Medicare/Medicare Supplement

Your physician may or may not be a participating Medicare/Medicare Advantage provider. However, if your physician does participate in your Medicare plan we will bill as followed:

- If you have Medicare, we will bill Medicare. However, you are responsible for any amount that is not covered of that Medicare does not pay.
- If you have a Medicare HMO or PPO we will bill your insurance carrier. However you are responsible for applicable copayments, co-insurance, deductibles and any amounts that your insurance does not cover or does not pay.
- If you have a Medicare supplement plan, we will bill Medicare and your supplement plan. However, you are responsible for any amount that is not covered or paid by Medicare or your supplement plan.

Other Fees

- Copy of medical records *($15 for the first report; 10¢ per sheet thereafter)*
- Form completion fees
- School Forms
- Charge for Return checks

Initial the following:

_____ I understand that I am responsible for paying all copayments, coinsurances and outstanding deductibles in full at the time services are received and if I'm a self-pay patient payment in full will be required at the time services are received.

_____ I understand that I am ultimately financially responsible for payment of all services received. I have read and understand my financial responsibilities.

_____
Name of Patient (Please Print)

_____
Signature of Patient or Guardian

_____
Date

Kern Allergy Medical Clinic

Patient Name: _____

Primary doctor: _____

Referring doctor: _____

New Patient Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Please take time to complete this questionnaire before your appointment. **Thank you!**

Main reason for today's visit:

_____

PATIENT HEALTH HISTORY: Please check any current and/or past problems.

___ Asthma
___ Arthritis / Rheumatoid Arthritis_____
___ Anemia
___ Autoimmune disorder
___ Infections Disease (HIV/TB)
___ COPD
___ Cancer, if yes please specify which type: _____
___ Crohn's Disease
___ Diabetes if yes please specify which type: _____
___ Neurological Disorder / Seizures
___ Psychological Disorder / Depression / Anxiety
___ Hypertension
___ Hypothyroidism
___ High Cholesterol
___ Heart Disease
___ Gastrointestinal Disorder, Heartburn or Indigestion
___ Kidney disease
___ Osteoporosis

What medications are you currently taking? (Include over-the-counter products, vitamins, and herbal remedies)

_____ _____
_____ _____
_____ _____

Have you been hospitalized? Please list approximate dates and reasons:

_____ _____
_____ _____

Have you had surgery? Please list approximate dates and reasons:

_____ _____
_____ _____

Do you have any medication allergies? Yes ____ No ___
If **YES** please list:

_____

IMMUNIZATIONS:
Did you have the influenza vaccine this season? Yes ___ No ___

(OVER)

New Patient Health History Form – Page 2

FAMILY HISTORY (Please indicate family members with any of the following conditions):

	Mother	Father	Sibling
Allergies	☐	☐	☐
Hay fever	☐	☐	☐
Chronic stuffy/runny nose	☐	☐	☐
Sinus problems	☐	☐	☐
Asthma	☐	☐	☐
Allergies to food	☐	☐	☐
Immunologic disorder	☐	☐	☐
Respiratory diseases	☐	☐	☐
Skin disorders	☐	☐	☐
Heart Disease	☐	☐	☐
Cancer	☐	☐	☐
Thyroid disease	☐	☐	☐
Diabetes	☐	☐	☐
High blood pressure	☐	☐	☐
Other _____	☐	☐	☐

ENVIRONMENT/SOCIAL HISTORY:

Do you have pets at home? Yes ___ No ___

What type of flooring is in the home? Circle all that apply
Carpet Tile Laminate Wood Other:_____

If **YES**, please circle: Cat Dog Bird Other:

_____

SMOKING HISTORY

- Do you smoke? Yes ___ No ___ Have you ever smoked? Yes ___ No ___ Quit Date: _____
- How many packs per day? _____ # of years _____
- Are there any smokers living in the home? Yes ___ No ___

Have you had previous allergy testing done thru lab work or skin test? If so please list when and where testing was performed (ex; Quest Diagnostics, PAL, Foundation Lab, LabCorp or doctor's office):

_____

FOR WOMEN ONLY: When was your last Pap smear? (Please list approximate date done)

_____

When was your last Mammogram? (Please list approximate date done)

_____

When was your last Colonoscopy? (Please list approximate date done)

_____

FOR MEN ONLY: When was your last Colonoscopy? (Please list approximate date done)

_____

In Office Use Only:
Reviewed by: _____