Kern Allergy Medical Clinic, INC
Tonny Tanus, M.D. Eric J Boren, M.D.
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 ali 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, Of patient is under 18yrs) or Patients

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 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 1/17

Tonny Tanus, MD
Eric J. Boren, MD
Board Certified Adult & Pediatric

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician- patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do no hesitate to ask a member of our staff.

Patient Registration

1. A copy of your current insurance card, drivers license and verification of your address is required **at every visit**. You are responsible for ensuring your address and insurance on file are correct. You are responsible for any unpaid balances or fees that arise if this information is not updated.

Cancellations & No Show Policy

1. Missed appointments not only impact you, but other patients waiting to be seen. If you are unable to keep your appointment, we require 24 hours' notice to cancel so we can open this time up for other patients to schedule. If you do not call within 24 hours you are subject to
   $30 fee for any missed appointment
   $50 fee for any missed procedure appointment (Skin Test or Pulmonary Function Test)

Insurance Coverage

1. As a courtesy, Kern Allergy will verify your coverage and will file insurance claims to your primary and secondary insurance carrier. If the secondary does not cover the balance owed from the primary insurance, you are responsible for any balance on the account.
2. Patients are expected to pay for all estimated co-payments, deductibles, and coinsurances at the time of service. If you are unable to pay your co-pay and any other patient responsibility at the time of service, you will be asked to reschedule. If you have a Deductible exceeding $500, you may be required to provide deposit or credit card information. (See end of form)
3. If our physicians do not participate in your insurance plan, payment in full for your visit is due at the time of your visit.

Insurance Authorizations

1. It is your responsibility to understand your insurance benefit plan, and to know if a written referral or authorization is required to see the specialist. Often a preauthorization is required prior for procedures. We strongly urge you to contact your insurance company prior to your appointment for detailed benefit coverage, policy limitations, and non-covered service.

Payment

1. Patients with outstanding balances over 60 days with any unpaid portions will be billed to your credit card or debit card on file. Appointments will not be scheduled and will not be provided refills until balance is paid in full.
2. A $50.00 fee will be charged for any checks returned, along with any bank fees included.
3. If you are requesting a copy of your medical records, there will be a $15.00 fee for the first report; 10 ¢per sheet thereafter.
4. Should you have forms that need to be completed and signed by the Physician you may be subject to a $25.00 fee for the first page and $5.00 for any additional forms.

Minor Patients

1. Patients under the age of 18 must be accompanied by the parent or guardian. *(Unless consented)*
2. The parent who consents for treatment will be the responsible party on the account and is responsible for all charges regardless of divorce or separation decree.
3. We request patients age 18 or older covered under their parent's insurance to sign an authorization allowing Kern Allergy Medical Clinic to contact parents regarding insurance and billing issues.

Termination/ Discharge from Practice

The following scenarios may jeopardize the patient/physician relationship in which Kern Allergy Medical Clinic will terminate and discharge the patient from the practice. The patient will be sent a letter of discharge.

- Noncompliance/ Abusive Patient
- Excessive no shows
- Failure to meet financial obligations
- Profanity
- Threats of social media retaliation

INITIAL THE FOLOWING:

______ I have read and understand Kern Allergy Medical Clinic Financial Policy and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

______ 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

Credit Card Terms and Conditions

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

I agree to have my credit/debit card charged to pay any balance on my account that goes over 60 days.

Please Note:

- Credit/ Debit cards will only be charged if the insurance applies any part of your visit towards deductibles, out of pocket, or if a coinsurance is processed for the services rendered.
- Your insurance will send an Explanation of Benefits (EOB) explaining the breakdown of your visits and or fees.
- If you have any questions or concerns about your claim, please call our billing department at (661) 327-9693 or email us at kamc_bill@hotmail.com

I hereby authorize Kern Allergy Medical Clinic to charge any and all outstanding balances after my insurance company reimbursement or denial to my credit/debit card. 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 above.

First Name: ____________________ **Last Name:** ______________________ **D.O.B:** _______________

Responsible party (guarantor) name if different and relationship:

____

Responsible Party/Patient Signature: ____

Date: _______________________________

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/ Lupus/ Epstein Barr/ CVID
___ Infections Disease (HIV/TB)
___ COPD
___ Cancer, if yes please specify which type: ______________________
___ Crohn's Disease
___ Diabetes if yes please specify which type: ______________________
___ Fibromyalgia/ Multiple Sclerosis
___ Neurological Disorder / Seizures
___ Psychological/Mental Disorder/ Depression / Anxiety Other: __________
___ Hypertension
___ Hypothyroidism
___ High Cholesterol
___ Heart Disease
___ Gastrointestinal Disorder, Heartburn or Indigestion
___ Kidney disease
___ Osteoporosis
___ Urticaria/ Dermatitis/ Eczema

Are you currently pregnant or expect to become pregnant? Yes ______ No ______

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	Bother	Sister	Other:__________ (specify relationship)
Allergies	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Chronic stuffy/runny nose	☐	☐	☐	☐	☐
Sinus problems	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Allergies to food	☐	☐	☐	☐	☐
Immunologic disorder	☐	☐	☐	☐	☐
Respiratory diseases	☐	☐	☐	☐	☐
Skin disorders	☐	☐	☐	☐	☐
Coronary Heart Disease	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Cancer: **(Specify what type*)** __________	☐	☐	☐	☐	☐

ENVIRONMENT/SOCIAL HISTORY:

Do you have pets at home? Yes ___ No ___

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

What type of flooring is in the home? Circle all that apply

Carpet Tile Laminate Wood Other:____________

____

SOCIAL BEHAVIORS:

- Smoking Status: ☐ Current ☐ Former ☐ Never
- Passive Smoke: ☐ Yes ☐No
- HIV Risk: ☐ Yes ☐ No
- Drug Use: ☐ Yes ☐ No
- Alcohol Use: ☐ 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):

____

WORKPLACE ENVIRONMENT:

Do you work in/outdoors? __________________ Occupation: __________________

FOR WOMEN ONLY:

When was your last Pap smear? (Please list approximate date done- if you've had a Hysterectomy list date of surgery)

____

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)

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Requesting records from: ____________________ or Send records to: ____________________

____________________ ____________________

____________________ ____________________

Patient Name: ______________________________ DOB: ____________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal/claim and or continued medical care. I expressly request that the designated record custodian of all covered entities under HPPA identified about disclose full and complete protected medical information including the following:

Type of Information being requested					
Please (X) which apply		Approx. Date(s)	Please (X) which apply		Approx. Date(s)
Allergy testing			Radiology Reports (CXR, CT Scan, MRI, other)		
Laboratory Report(s)			Pulmonary Function Test(s)		
Endoscopy Reports(s)			Urgent Care/Emergency Room Report(s)		
If other please specify:					

Release protected health information to the following persons/organization:
Kern Allergy Medical Clinic
1921 18th St
Bakersfield, CA 93301
Tel: (661) 327-9693 Fax: (661) 327-0749
allergykern@gmail.com

For the following purposes please (X) which applies

_______ Medical Care
_______ Attorney Use
_______ Personal use
______ To obtain additional benefits
______ Payment of a claim
______ other ____________________

This Authorization will expire 180 days from the date I sign it as evidenced below or until
I may revoke this authorization at any time, provided that I do so in writing and deliver the revocation to Kern Allergy Medical Clinic, Inc., 1921 18th Street, Bakersfield, CA 93301. My revocation will be effective upon receipt, and I know that previously disclosed information will not be subject to my revocation.

I understand that if I have authorized the disclosure of information to a person or entity that is not legally required to keep it confidential the information may be re-disclosed and may no longer be protected. Therefore I release Kern Allergy Medical Clinic, Inc. and its employees from liability and all legal responsibility arising from this disclosure of health information.

Date:____________________ Signature:______________________________

**If signed by someone other than the patient, state your legal relationship to the patient____________________

Office USE Only:

Office Staff/ Money received by: ____________________ Amount Paid/Fee: ____________________