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

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 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: _____

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

Date: _____

Kern Allergy

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 hour's 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.
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. If payment arrangements have not been made with our billing department prior, 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 report and $5.00 for any additional forms.

Minor Patients

1. Patients under the age of 18 must be accompanied by the parent or guardian.
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

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.

_____

Name of Patient (Please Print)

_____

Signature of Patient or Guardian

_____

Date

Kern Allergy

Tonny Tanus, M.D • Eric Boren, M.D

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: _____

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.

___ Alcoholism
___ Anemia
___ Arthritis / Rheumatoid Arthritis_____
___ Asthma
___ Autism
___ Autoimmune Disorder/ Lupus/ Epstein Barr/ CVID
___ Cancer, if yes please specify which type: _____
___ Cholesterol
___ COPD
___ Crohn's Disease
___ Diabetes if yes please specify which type: _____
___ Fibromyalgia/ Multiple Sclerosis
___ Hypertension
___ Hypothyroidism
___ Infections Disease (HIV/TB)
___ Migraines
___ Neurological Disorder / Seizures
___ Osteoporosis
___ Psychological/Mental Disorder/ Depression / Anxiety Other: _____
___ Urticaria/ Dermatitis/ Eczema
___ Valley Fever

♦ 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:

♦Flu shot last received: _____ ♦ Covid vaccine? Yes ___ No ___ Brand: _____ Quantity: ____

WORKPLACE ENVIRONMENT:

Do you work indoors/outdoors? _____ Occupation: _____

(OVER)

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

	Mother	Father	Brother	Sister	Other:_____ (specify relationship)
Alcoholism	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐
Congenital Heart Disease	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Eczema (Atopic dermatitis)	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Hemophilia	☐	☐	☐	☐	☐
Immunologic Disorder	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Urticaria (Hives)	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐
Valley Fever	☐	☐	☐	☐	☐

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 specify type and if they are indoors/outdoors or both:

_____

SOCIAL BEHAVIOR

- 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):

_____

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)

_____

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

_____

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