FamilyCare
ALLERGY & ASTHMA

For over 35 years serving our patients in northern California. Offices in Santa Rosa, Petaluma and Marin.

Welcome to our Office!

- Please bring the ***3 enclosed patient forms*, *your insurance cards*, *and identification*** to your first visit. We thank you for scheduling with us, and look forward to your appointment. It will be with a member of our experienced, highly skilled medical staff.

  - **Dr. Maria (Mima) M Petrick, MD FACAAI FAAAAI**
    Board Certified Allergist/Clinical Immunologist

  - **Dr. Juline (Julie) N Caraballo Fonseca, MD**
    Board Certified Allergist/Clinical Immunologist

  - **Andria Steinkamp, MSN-FNP.**

    They are teamed up with our specialty-specific professional nursing staff, and exceptional front office organization!

  - **APPOINTMENT TIME:**
    Your first visit is lengthy. If you are unable to keep the appointment***, please call us immediately*** so that others may schedule.

  - **YOUR INITIAL VISIT:**
    Since this is an important evaluation, we plan for **1½ hours of office time,** which typically includes skin testing. Your attention is essential, so we ask that only the patient ***without any additional children*** attend***. If the patient is a child or minor (Under the age of 18) a parent or legal guardian must attend.***

  - **CONFIRMATION POLICY:**
    Due to the demand of our appointments we do require a confirmation call to confirm your appointment, our office will reach out closer to the scheduled appointment date and patients will have a couple of days to call us back and confirm, failure to do so **will result in your appointment being canceled.**

Allergy skin testing is generally done at the first visit, and as antihistamines interfere with testing, ***do not take any antihistamine medications for seven days prior to your appointment. Do not stop taking other medications, especially those for asthma (inhalers) or for other health problems.*** *If* you do take an antihistamine, ***please keep your appointment.*** The skin test can/will be rescheduled.

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ASPECTS OF YOUR FIRST VISIT:

1. Review of history with analysis of past records if available.
2. Physical examination from the waist up with emphasis on the organ system of most concern.
3. Laboratory examination and lung function determination for patients with chest complaints.
4. Medical records are generated, transcribed and sent to the family physician.
5. Initiation of medical treatment.

ATTACHED PATIENT QUESTIONNAIRES:

Patient participation in the diagnostic and treatment process is very beneficial. ***Your assistance in providing complete and accurate responses to these questions are crucial to our providing the best options available.*** These forms help organize your concerns and provide focus on the issues you want resolved.

Again, thank you and we look forward to meeting soon!

Sincerely,

FamilyCare Staff

***For additional information and background, please visit our website*: www.familycareallergy.com**

- ***Santa Rosa Office*** 130 Stony Point Road Suite E
  Santa Rosa, CA 95401
- ***Petaluma Office*** 1383 N. McDowell Blvd. Suite 130
  Petaluma, CA 94954
- ***Marin Office*** 4000 Civic Center Dr. Suite 300
  San Rafael, CA 94903

For any Office Call:
707-525-0211

FamilyCare
ALLERGY & ASTHMA

PATIENT REGISTRATION

PLEASE PRINT & COMPLETE SECTIONS 1-4

Phone: 707-525-0211
www.familycareallergy.com
email: frontoffice@familycare-allergy.com

Patient's Name

(First) (Middle) (Last) (Nickname)

Mailing Address City Zip

Home Phone: ( )_____ Cell/Mobile Phone: ( )_____

Child Ms. Miss
Mrs. Mr. Dr.

___ Male____ Female Date of Birth ____/____/_____ Age_____

Social Security Number: _____-____-_____ Driver's License Number: _____ Exp: _____

Patient's Primary Care Physician (First & Last Name) Phone:

Person to Notify in Emergency: Relationship to Patient:

City Home Phone ( ) - Work/Cell Phone ( ) -

Spouse/Partner Name Patients primary communication language (circle one): English---Spanish---Other

RESPONSIBLE PARTY INFORMATION - SECTION 2

Parent/Legally Responsible Party Name:

Address (if different from above) City Phone

Social Security Number Driver's License Number

INSURANCE INFORMATION - SECTION 3

Primary INS Subscriber's Name Date of Birth

ID# Group/Plan#

Secondary INS Subscriber's Name Date of Birth

ID# Group/Plan#

EMPLOYMENT INFORMATION - SECTION 4

Patient's Employer (Legally Responsible Person, if patient is a minor) _____ Work Phone ( )_____

Occupation _____

Partner/Spouse's Employer (if patient is a minor):_____ Work Phone ( )_____

Occupation_____

FUTURE APPOINTMENT AND FOLLOW UP CONTACT INFORMATION

Email Address:_____ For Text Notifications, which number is best?:( )_____

TREATMENT AUTHORIZATION AND FINANCIAL AGREEMENT (SIGN BELOW):

- I authorize treatment of the patient named above and agree to pay all charges at the time services are rendered unless other arrangements agreed upon in advance. **I acknowledge that I am ultimately responsible for determining any insurance benefits/coverages prior to my visit(s).** If any payment required on my account is over 30 days late, all associated fees, including collection and attorney fees, plus interest (1.5% per month-APR 18%) will be my responsibility.
- I hereby authorize the release of any information necessary for payment of charges incurred.
- For patients who fail to notify us in writing of any change in your medical coverage or any change in your Primary Care Physician, or Medical Group (HMO-Managed Care plans), we retain the right to charge for any non-covered services.

Signature Date

Signature Date

IF THE PATIENT IS A MINOR, I understand I or my legal guardian must be present for any/all medical related questions or assessments, and must remain so during any treatment process including allergy injections if prescribed.

Santa Rosa *130 Stony Point Road, Suite E, Santa Rosa, CA 95401*
Petaluma *1383 North McDowell, Suite 130, Petaluma, CA 94954*
Marin *4000 Civic Center Drive, Suite 300, San Rafael, CA 94903*
Phone: (707) 525-0211

ALLERGY HEALTH & ENVIRONMENT QUESTIONNAIRE

(Questionario de Alergia)

Patient's Name *(Nombre del paciente)*_____Date of Birth *(Fecha de nacimiento)* _____
Age *(Edad)*_____ Visit Date *(Fecha de la visita médica)* _____
Primary Care Provider *(Doctor de cabecera)* _____
How did you hear about us? *(Cómo supo de nuestra clínica?)* _____
What is/are the main reason(s) for your office visit with us? *(Cuál es la razón por la cuál nos visita hoy?)* _____
_____

Check "√" if you are currently bothered by the following symptoms:
(Indique con un check "√" si Usted tiene los siguientes síntomas)

___Swollen lymph nodes *(Glándulas inflamadas)*
___Rash *(Erupción)*
___Itching *(Picor/Picazón)*
___Fatigue *(Fatiga)*
___Fever *(Fiebre)*
___Red eyes *(Ojos rojos)*
___Runny nose *(Mucosidad de nariz)*
___Nasal congestion *(Congestión nariz)*
___Itchy nose/throat *(Picor nariz/garganta)*
___Bouts of sneezing *(Estornudos)*
___Postnasal drip *(Drenaje postnasal)*
___Itchy/watery eyes *(Picor de ojos)*
___Headaches *(Dolor de cabeza)*
___Loss of taste/smell *(No puede oler)*
___Hoarseness *(Cambio de voz)*
___Throat clearing *(Aclarar garganta)*
___Ear fullness/popping *(Presión de oído)*
___Ear pain *(Dolor de oído)*
___Sinus pain/pressure *(Presión en cara)*
___Sore throat *(Dolor de garganta)*
___Wheezing on exertion *(Sibilantes con ejercicio)*
___Chest tightness *(Presión de pecho)*
___Cough *(Tos)*
___Shortness of breath *(Difícil respirar)*
___Wheezing *(Sibilantes)*
___Heartburn *(Reflujo de ácido)*
___Nausea *(Náuseas)*
___Vomiting *(Vómitos)*
___Difficulty urinating *(Dificultad al orinar)*
___Joint pain *(Dolor de articulaciones)*
___Fainting *(Desmayo)*
___Depression *(Drepresión)*
___Palpitations *(Palpitaciones)*
___Anxiety *(Ansiedad)*

Other (list): _____

Past Medical/Surgical History: Check "√" if you have a history of the below conditions:
*(**Historia Médica/Quirúrgica:** Indique con un check "√" si Usted ha tenido/tiene las siguientes condiciones:)*

___Eczema *(Dermatitis atópica)*
___Asthma *(Asma)*
___COPD *(EPOC)*
___Pneumonia *(Neumonía)*
___Frequent bronchitis *(Bronquítis frequentemente)*
___Nasal polyps *(Pólipos nasales)*
___Freq sinus infections *(Sinusitis frequentemente)*
___Sinus surgery *(Cinugía nasal)*
___Frequent ear infections *(Infecciones de oído frequentemente)*
___Tubes in ears *(Tubos en oídos)*
___Tonsillectomy *(Amigalectomía)*
___Adenoidectomy *(Adenoidectomía)*
___Migraine headaches *(Migrañas)*
___GERD *(Reflujo gástrico)*
___Severe allergic reaction, explain to what *(Reacción alérgica severas, indique a qué)* _____

Other (list): _____

If you have asthma, please complete the following information: *(Si Ud. tiene asma, por favor complete la siguiente información:)*
Diagnosed when? *(Cuándo fue diagnosticado?)* _____
ER visits for asthma/year *(# de visitas al ER por asma al año)* _____
Last ER visit for asthma? *(Cuándo fué la última visita al ER por asma?)* _____
Hospitalizations for asthma? *(Ha sido hospitalizado por asma?)* _____
Last hospitalization for asthma? *(Cuándo fue la última hospitalizacion por asma?)* _____
Days missed/year from work/school) due to asthma? *(Cuántos días faltó al trabajo/escuela por asthma en el último año?)* _____#
Office visits/year due to asthma? *(Cuántas visitas médicas tiene al año por asma?)* _____ #
Courses steroids/year for asthma? *(Cuántas veces al año toma esteroides por asma?)* _____ #

(Continued on Reverse Side)
(Continúa en el otro lado)

Patient's Name *(Nombre del paciente)*_____Date of Birth *(Fecha de nacimiento)* _____

Family History: Check "√" if anyone in your family has one of these conditions:
*(**Historia Familiar:** Indique con un check "√" si alguien en su familia tiene alguna de las siguientes condiciones:)*

___Allergies *(Alergias)*
___Sinus Problems *(Problemas nasales)*
___Eczema *(Dermatitis atópica)*
___Asthma *(Asma)*
___Chronic bronchitis *(Bronquítis crónica)*
___Emphysema *(Enfisema)*
___Immunodeficiency *(Inmunodeficiencia)*
___Autoimmunity *(Autoinmunidad)*
___Cystic Fibrosis *(Fibrosis Cística)*

Other (list:)_____

Social/Environmental History: Check "√" if any of the below apply to you:
*(**Historia Social/Ambiental:** Indique con un check "√" si los los siguientes aplican a Usted:)*

___Current smoker *(Actualmente fuma)*
___Previous smoker (Fumó en el pasado)
___Second-hand smoke exposure
(Está expuesto al humo de segunda mano)
___Indoor/outdoor pets (Tiene mascotas)
___Mold exposure (Expuesto al moho)
___Work allergen/irritant exposure
(Alérgeno/Irritantes en el trabajo)
___School allergen/irritant exposure
(Alérgeno/Irritantes en la escuela)
___Daycare exposure (*Asiste a guardería)*
Others *(Otros)*: _____

CURRENT MEDICATIONS (Please list NAME/DOSAGE/FREQUENCY)
*(**Medicamentos que toma actualmente** – Por favor indique NOMBRE/DOSIS/FRECUENCIA)*
1.)_____
2.)_____
3.)_____
4.)_____
5.)_____
6.)_____
7.)_____
8.)_____
9.)_____
10.)_____
(Attach list if additional space is needed) *(Si necesita espacio adicional, anada una lista de sus medicamentos en una hoja separada)*

PREVIOUS ALLERGY/ASTHMA MEDICATIONS USED ***(Medicamentos para asma/alergia que uso previamente)***
1.)_____
2.)_____
3.)_____
4.)_____
5.)_____
6.)_____

KNOWN DRUG ALLERGIES:***(Alergias a medicamentos):***_____

CURRENT PHARMACY (Name/Location/Phone) ***(Farmacia)***:_____
_____

Do you have a written advanced care directive?*(Tiene direcciones escritas de cuidados avanzados?)* Yes*(Si)*__No*(No)*__

I understand the information provided by me will be used in the assessment, diagnosis, and treatment of my condition(s).
(Yo entiendo que la infomación dada en esta forma sera usada en mi visita para el diagnóstico y tratamiento de mi condición(es) médica)

Printed Patient Name *(Nombre del paciente)*: _____

Printed Legal Guardian Name *(Nombre del Guardián Legal)*: _____

Signature of Patient or Legal Guardian *(Firma del Paciente o del Guardián Legal)*: _____

FamilyCare ALLERGY & ASTHMA

MEDICATIONS TO DISCONTINUE PRIOR TO SKIN TESTING***

BRAND NAME	GENERIC NAME	USAGE/ROUTE
Actifed	diphenhydramine	allergies/colds/flu
Alavert	loratadine	allergies/hives
Alaway/Zaditor	ketotifen	itchy eyes/allergies
Allegra	fexofenadine	allergies/hives
Antivert	meclizine	nausea/vomiting/dizziness
Astelin	azelastine	nose allergies
Atarax	hydroxyzine	allergies/hives
Benadryl	diphenhydramine	allergies/colds
Chlor-Trimeton	chlorpheniramine	allergies/colds/eye
Clarinex	desloratadine	allergies/hives
Claritin	loratadine	allergies/hives
Comhist	chlorpheniramine	allergies/colds
Compazine	prochlorperazine	nausea/vomiting
Dimetapp	brompheniramine/pseudoephedrine	decongestant
Dramamine	dimenhydrinate	nausea/vomiting
Dymista	azelastine and fluticasone	nose allergies
Elavil	amitriptyline	tricyclic antidepressant
Extendryl	chlorpheniramine/methscopolamine	antihistamine
Livostin	levocabastine opth	allergic conjunctivitis
Nyquil	doxylamine	antihistamine/decongestant/cough
Optivar	azelastine	eye allergies
Patanol/Pataday	olopatadine	itchy eyes/allergies
Pazeo	olopatadine hydrochloride	itchy eyes/allergies
Pepcid	famotidine	stomach acid
Phenergan	promethazine	nausea/vomiting
Prorex 25 &50	promethazine	motion sickness
Remeron	mirtazapine	atypical antidepressant/sedative
Rynatan	chlorpheniramine/phenylephrine	allergies/colds/congestion
Tagamet	cimetidine	stomach acid
Sinequan	doxepin	tricyclic antidepressant
Triaminic	chlorpheniramine/phenylpropanolamine	allergies/hives/colds
Tussionex	chlorpheniramine/hydrocodone	cough/colds/congestion
Tylenol PM	diphenhydramine	sleep
Verticalm	meclizine	nausea/vomiting
Vistaril	hydroxyzine	anxiety
Xyzal	levocetirizine	antihistamine
Zaditor/Alaway	ketotifen	itchy eyes/allergies
Zantac	ranitidine	ulcers/stomach acid
Zyrtec	cetirizine	allergies/hives

******NEVER* Stop Anti-Depressants or Anti-Psychotics without prior consultation with, and approval from your Primary Care Physician.**

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION

FamilyCare Allergy & Asthma-AAAPMG, Inc.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you pursuant to the federal law known as HIPAA. If you have any questions about this notice, please contact the Privacy Officer at 130 Stony Point Road, Suite E, Santa Rosa, CA 95401 or via email at frontoffice@familycare-allergy.com.

Who Will Follow This Notice.

This notice describes the medical information practices of all group health plans maintained by FamilyCare Allergy & Asthma and that of any third party that assists in the administration of Plan claims. The Plan has been amended to incorporate the requirements of this notice.

Our Pledge Regarding Medical Information.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the use and disclosure of your medical information created in the doctor's office or health provider's facility.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law (1) to make sure that medical information that identifies you is kept private, (2) give you this notice of our legal duties and privacy practices with respect to medical information about you, and (3) follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment.
We may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

For Payment.

We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations.

We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

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To Business Associates.

We may contract with individuals and entities known as Business Associates to perform various functions or provide certain services. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose your medical information, but only after they sign an agreement with us requiring them to implement appropriate safeguards regarding your medical information. For example, we may disclose your medical information to a Business Associate to administer claims or to provide support services, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law.

We will disclose medical information about you when required to do so by federal, state or local la. For example, we must disclose medical information when required by the U.S. Department of Health and Human Services pursuant to an investigation regarding the Plan's HIPAA compliance. Further, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety.

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

Disclosure to Health Plan Sponsor.

Information may be disclosed to another health plan maintained by Employer for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Employer personnel solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation.

If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans.
If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation.
We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks.
We may disclose medical information about you for public health activities, such as to prevent or control disease, injury or disability, report births and deaths, or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities.
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement.
We may release medical information if asked to do so by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons or similar process, (2) to identify or locate a suspect, fugitive, material witness, or missing person, (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement, (4) about a death we believe may be the result of criminal conduct, (5) about criminal conduct at the hospital, and (6) in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors.

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities.

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Your Rights Regarding Medical Information About You:

Right to Access.

You have the right to request access to the portion of your protected health information containing your enrollment, payment and other records used to make decisions about your Plan benefits. This includes the right to inspect the information as well as the right to a copy of the information. You must submit a request for access in writing to the Privacy Officer. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Health care providers may create, gather or manage certain electronic health records regarding your health information. Beginning in 2011 (or such later date prescribed by law), to the extent those records are in the possession of the Plan, you will have the right to request access to the electronic health records. If you submit such a request and we maintain any such records, we will charge you our actual labor costs to comply with your request.

Right to Amend.

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: is not part of the medical information kept by or for the Plan; was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures.

You have the right to request an “accounting of disclosures” of your protected health information containing your enrollment, payment and other records used to make decisions about your Plan benefits, where such disclosure was made for any purpose other than treatment, payment, or health care operations. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the reasonable costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, health care providers may create, gather or manage electronic health records regarding your health information. Beginning in 2011 (or such later date prescribed by law), to the extent those records are in the possession of the Plan, you will have the right to request an accounting of the disclosures of the electronic health records (including for purposes of treatment, payment or health care operations) during the three years that preceded the request.

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Right to Request Restrictions.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice.

If you received this notice electronically, you have the right to a paper copy of this notice. You may ask us to give you a paper copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

Breach Notification Requirements.

Beginning as of September 23, 2009, in the event unsecured protected health information about you is “breached” and the use or disclosure of the information poses a significant risk of financial, reputational or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against potential harm due to the breach. We will also inform HHS and take any other steps required by law.

Changes to this Notice.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

Complaints.

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Effective Date:

This notice is effective January 1st, 2018.

I have read, and understand my rights and potential uses of my personal medical information

_____

Printed Name/Signature Date

FamilyCare
ALLERGY & ASTHMA

PAYMENT POLICY*

*(*Patients are ultimately responsible for determining their insurance coverage/benefits prior to service.)*

HMO & EPO (BLUE CROSS, HEALTHNET, PACIFICARE, ETC.)

Referrals: All HMO's and EPO's require REFERRALS prior to receiving allergy specialty care. All referrals must be received in our office prior to scheduling appointments. Without the correct referral; you would be held fully responsible for the cost of the visit.
Benefits: Individual HMO groups have different covered benefits. It is important to review your benefits. A referral for services does not guarantee payment for a non-covered service.
Payment: The copay is due at the time of the visit.

PPO (BLUE CROSS, BLUE SHIELD, FIRST HEALTH, ETC.)

Referrals: Traditional PPO plans do not require referrals. If you are uncertain, please call your insurance company.
Benefits: Currently most PPO's cover our services. If you are uncertain, please call your insurance company.
Payment: Most plans require payment of a yearly deductible ($250-$5000) and then a percent (10%-30%) of services. New plans offer a co-payment for office visits ($5-$60) and then deductible and percent payment on all additional services. **A partial payment of 20% is due at the time of service.**

PRIVATE INSURANCE: (NON-CONTRACTED)

Referrals: We are contracted with most plans. Please contact your insurance regarding their referral policy.
Benefits: It would be a good idea to confirm with your specific plan that allergy treatment is a covered benefit.
Payment: Payment is due at the time of service. We accept cash, check, MasterCard or Visa. Payment arrangements can be made for costlier initial visits.

MEDICARE

Referrals: No referral is required
Benefits: Currently all our services are covered benefits
Payment: No payment is required at the time of service. We accept assignment from Medicare.

MEDI-CAL/PARTNERSHIP HEALTHPLAN

Referrals: A referral is required from your primary care physician. A referral authorization must be received in our office prior to scheduling appointments.
Benefits: Currently all our services are covered benefits provided you meet eligibility requirements for the month when services are rendered.
Payment: No payment is required at the time of service.

PRIVATE (NO INSURANCE)

Referrals: Not required
Benefits: Not applicable
Payment: Payment is due at the time of service and you will receive a 25% discount. We accept cash, checks, MasterCard or Visa.

If you have any questions, PLEASE do not hesitate to ask us. We are here to help you!

Thank you,

Deborah Finger
Director-Patient Accounts/Credentialing
Telephone (707) 525-0211

FamilyCare
ALLERGY & ASTHMA

Office Information:

Our Santa Rosa office is located at:

130 Stony Point Road, Suite E, Santa Rosa, CA 95401

Phone: 707-525-0211

Office Hours Santa Rosa:

- **Monday thru Wednesday: 10:00am - 6:00pm**
- **Thursday & Friday: 10:00am - 5:00pm**

Our Petaluma Office is located at:

1383 N. McDowell Blvd., Suite 130, Petaluma, CA 94954

Phone: 707-789-6320

Office Hours Petaluma:

- **Tuesday thru Thursday: 10:00am - 12:00pm & 1:30pm - 6:00 pm**

Our Marin office is located at:

4000 Civic Center Drive, Suite 300, San Rafael, CA 94903

Phone: 415-847-4022

Office Hours Marin:

- **Tuesday thru Friday: 10:00am - 12:00pm & 1:30pm - 6pm**

Notice of Behavioral Standards at FamilyCare Allergy and Asthma

As your health care partner, we hold ourselves to the highest standards. We pledge to treat you with respect, honesty, dignity, and compassion.

We ask you, our patients and your family or visitors, for your support to keep this a place of mutual respect. We ask you to treat others with respect, honesty, dignity, and compassion.

- **Mistreatment & Discrimination**

FamilyCare Allergy and Asthma is a place of healing. Mistreatment and discrimination towards staff or providers are not allowed. It is not allowed in person, on the phone, in written form, or in any other setting. This includes any patient or visitor behavior that:

- Interferes with a safe environment
- Limits staff or providers from giving patient care
- Is abusive to anyone with the patient or anyone on the care team
- Can be viewed as discriminatory or racist in towards staff or providers

- **Examples of Mistreatment & Discrimination**

- Racism towards staff or providers (for example: microaggressions or bigotry)
- Discrimination against someone based on their gender identity and expression, sexual orientation, race, religion, age, disability, or other traits
- Verbal abuse (for example: Name calling, cursing, belittling, or ranting)
- Emotional abuse (for example: Acts that make staff feel unsafe or uncomfortable, or stalking)
- Sexual abuse (for example: Unwanted touching or sexual language)
- Threatening acts (for example: Slamming doors, blocking, yelling, or bullying)
- Physical abuse (for example: Hitting, kicking, or spitting)

- **Our response to Mistreatment & Discrimination**

When mistreatment or discrimination occurs, a team will decide how to respond. Any mistreatment or discrimination could result in consequences up to and including:

- Reporting behavior to other staff members (for example: Managers or senior staff)
- Removal from the clinic
- Restriction of individuals who mistreat staff and providers (for example: an individual mistreating staff will not be allowed to remain the patient if the patient is an adult. If patient is a minor the appointment will be terminated.)
- Asking patients to leave instead of receiving care, treatment, or services temporarily (for example: Patients mistreating providers will not be allowed to go to their appointment)
- Prohibiting a patient from receiving care in outpatient clinics at FamilyCare Allergy and Asthma, except for emergency services
- Calling local authorities/law enforcement

Please report any mistreatment or discrimination you observe to a staff member or physician/provider.

Patient/Guardian Name:_____Signature/Date:_____