Allergy Asthma Immunology of Rochester, PC

TO BE COMPLETED BY PATIENT (IF 18 YEARS OR OLDER), parent, guardian or personal representative.
Please fill out this form completely. There are **5** sections, **5 of which require your signature**. If a particular section does not apply to you, please write N/A. **This form has 2 sides.**

Section 1

Patient Information:

Patient Name:____DOB:_________________________

Gender:_____ Race:________ Ethnicity: Hispanic Non-Hispanic Preferred Language:_________________________

Address:____

Home Phone:_____________________ Cell Phone:___________________ Work Phone: ____________________

****The practice will use any available phone numbers that you provide, to contact you regarding appointments, call backs, insurance matters, and/or account balances. Your signature indicates your agreement with our policy.***

Signature:____ **Date:**__________________________

Emergency Contact Name:_____________________________________ Relationship:____________________

Home Phone:_____________________ Cell Phone: ____________________ Work Phone: ____________________

Section 2

HIPAA-Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was offered a copy of the Notice of Privacy Practices for AAIR, PC.

Signature:____ **Date:**______________________________

I authorize AAIR, PC **to verbally discuss** patient medical information with: (who can call regards to your appointment, prescription refills, etc.)

Name(s) of individual(s):____Relationship:____________________

Signature:____ **Date:**______________________________

COPIES of your medical records to the above named individual(s) will ONLY be provided to the above upon your signed records release authorization.

OVER PLEASE →

Section 3

Electronic Prescription

AAIR, PC sends prescription orders to and receives prescription refill requests electronically from pharmacies. This expedites the request and allows for our providers to see your full prescription drug history and in some cases is mandated by insurers.

I agree to have AAIR, PC electronically send and receive prescriptions and prescription drug history: **Yes** **No**

Signature: ____ Date:__________________

Section 4

Authorization for Treatment

If your son, daughter or ward is **under 18 years of age OR is unable to give consent for treatment**, it is our policy to **clarify** and **secure** your consent for medical treatment in AAIR facilities. By signing below you will be giving your consent to all AAIR physicians, practitioners and medical personnel to render medical evaluation and treatment to your child or ward **in your absence**. A parent, guardian or personal representative **MUST** accompany the **minor child** (under 18 years of age) **or ward** to their first visit with our office and/or their first injection appointment. **Thereafter, in order for your MINOR child (under 18 years of age) or ward to attend their appointments <u>without</u> their parent, guardian or personal representative, you MUST SIGN BELOW.**

Signature of Parent, Guardian or Personal Representative:________________________________ Date:________

Section 5

Authorization for Payment of Insurance Benefits

I attest that the insurance information provided by me is correct and I authorize AAIR, PC to release any and all medical information necessary to my insurance carrier to process my claim for payment. I request that payment for my claim be made to AAIR, PC for services provided to me there.

Signature:____**Date**:____________

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Printed Name of Person Completing and Signing this form

Relationship to Patient:

____Self **___Parent** **___Guardian** **___Personal Representative**

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