ALLERGY AFFILIATES, INC.
JOHN P. CELLA, M.D.

Adult and Pediatric Allergy, Asthma and Immunology

West Office:
6220 Manatee Ave W, Suite 201
Bradenton, Florida 34209

(941) 792-4151
(941) 792-8463 (Fax)

East Office:
5307 State Road 64 East
Bradenton, Florida 34208

PATIENT INFORMATION

Name _____ Age _____ Date of Birth _____ Sex M/F _____
(Last, First, Middle)

SS# _____ Marital Status _____

Home Address _____
(Street, City, State & Zip)

Home Phone _____ Cell Phone _____ Work Phone _____
"I am fully aware that a cell phone is not a secure and private line"

Email Address _____

Occupation _____ Employer _____
(Name and Address)

Race _____ Ethnicity _____ Decline to Answer _____

Northern Address _____ (if applicable)

PARENT/SPOUSE INFORMATION

Name _____ Relationship to Patient _____
(Last, First, Middle)

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____
(Last, First, Middle)

Home Phone _____ Work Phone _____

REFERRAL INFORMATION

Who referred you to our office? _____

INSURANCE INFORMATION: Please submit all insurance cards so that we may copy them for our records.

LIFETIME SIGNATURE AUTHORIZATION: I certify that the above information is correct. In order to substantiate claims submitted to my insurance company, I authorize holders of medical and billing information to release needed information about me (or my child) for Medicare or insurance claims. Allergy Affiliates can share information with but not limited to: hospitals, diagnostic testing centers, physicians, home health agencies, pharmacies, therapy/rehab centers, attorneys and POA's. Medical information is included but not limited to: doctor's orders, RX requests, account information, conditions, diagnoses, procedures and results of ordered tests authorize payment of medical benefits to this office. I understand that I will obtain authorization, if necessary, prior to services: otherwise I accept the financial responsibility. I understand that I am responsible for deductibles, co pays, and/or coinsurance amounts AT THE TIME OF SERVICE. I authorize this office to send and receive medical information about me (or my child) and allow doctors and staff to discuss medical information with my doctors and personnel involved in my care. I understand that it may be necessary to transmit medical information electronically and I authorize you do so. If this information is received by another party in error, I absolve Allergy Affiliates of any and all liability related to such transmission of said information. I permit a copy of this authorization to be used in place of the original. If a patient is a child, I authorize doctors and staff at this office to treat my minor child as medically indicated in my absence.

I understand this authorization can be revoked by me at any time in writing.

Signature **Date** **Witness**

ALLERGY AFFILIATES
John P. Cella, M.D.

Date: _____

Patient Name: _____ Sex: M F
LAST **FIRST** **MIDDLE**

Age: _____

Allergy/Immunology History

Birthdate: _____

What is the main reason for your visit?

_____

When did your symptoms begin? _____

Are you having problems with any of the following? **Please circle the ones that apply.**

1. Ears, eyes, nose, throat

2 1	A. Ears:	popping	itching	fluid		
3 4	B. Eyes:	red	itchy	teary	puffy	
4 4	C. Nose:	congestion	runny nose	itching	sniffling	sneezing
5 4	D. Throat:	drainage	itchy throat/mouth		frequent sore throat	

Triggers for your symptoms:

dust	mold/mildew	animals	weeds
cut grass	outside	strong smells	bleach
air conditioning	weather change	perfumes	pollen
smoke	eating meals	other	

2. Chest

asthma shortness of breath wheezing chest tightness cough

3. Skin

itching rash hives swelling eczema

4. Reactions to food

itchy mouth	itchy throat	rash	swelling
nausea	vomiting	diarrhea	

What foods? Please list: _____

_____

5. Reactions to insects

large local reaction:	local rash	redness	swelling	
systemic reaction:	widespread rash/swelling	throat closing	wheezing	loss of consciousness

6. Reactions to latex

itchy skin	rash	swelling	wheezing
shortness of breath	cough	throat closing	loss of consciousness

_____

_____

_____

_____

_____

_____

Medications/Treatments tried for your symptoms? **Please list**

_____

_____

_____

Prior allergy testing? **Yes** **No** **Prior allergy shots?** **Yes** **No**

Past History

Patient Name: _____

Surgeries/Hospitalizations Please list with year: **Date:** _____

2 0 _____

3 1/3 _____

4 3/3 _____

5 3/3 _____

Medications

Please list (or attach list):

_____

_____

_____

Allergies to Medications Please list with name and type of reaction (eg. rash or swelling)

_____

_____

Family History of allergic disease

Please indicate which family member:

hayfever _____ asthma _____ eczema _____

hives _____ food allergy _____ insect allergy _____

Social History

Marital Status: S M D W Children: _____

Type of job: _____

Cigarettes: Currently? Yes No Amount_____ How long? _____

Previously? Yes No Amount _____ Quit when? _____

Do you drink alcohol? Yes No Amount _____

Do you live in Florida year round? Yes No How long in Florida? _____

Born: _____ Raised: _____ Hobbies: _____

Environmental History

City where you live: _____ House Condo Apt Mobile Home

How many years in current home? _____

Pets: Yes No Please list: _____

Feathers in the pillow? Yes No

Mattress: regular (inner spring) air waterbed foam rubber Other

Bedroom flooring: wall to wall carpet hard floors Flooring elsewhere: wall to wall carpet hard floors

Is your air conditioning? central air wall unit

Review of Systems

	Have you had any of the following symptoms?	**Please circle those that apply**		
2 1	**1. Constitutional**	recent weight loss	fever	fatigue
3 2 9	**2. Eyes**	vision loss	pain	glaucoma
4 (10+)	**3. Ears/Nose/Mouth/Throat**	nasal polyps	sinusitis	sinus surgery
5 (10+)		deviated septum	broken nose	
	4. Cardiovascular	cardiac disease	chest pain	high blood pressure
	5. Respiratory	sputum	pneumonia	frequent bronchitis
	6. Gastrointestinal	heartburn/reflux	peptic ulcer disease	frequent diarrhea
	7. Genitourinary	kidney disease	difficulty urinating	
	If female, date of last menstrual period _____		Is there any possibility of pregnancy? Yes / No	
	8. Musculoskeletal	joint swelling	joint or muscle pain	arthritis
	9. Skin	rashes	hives	swelling itching
	10. Neurological	migraines	frequent headaches	arm or leg weakness
	11. Psychiatric	depression	anxiety	
	12. Endocrine	diabetes/high blood sugar	thyroid problems	hormone problems
	13. Hematologic/Lymphatic	anemia	recurrent infections	swollen lymph nodes

14. Allergy/Immunology (See above H & P and Review of Systems)

All other systems reviewed and are negative _____

(Doctors Initials)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,

HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.

PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on June 15, 2014 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, John Cella, MD. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for each page and the staff time charged will be $15.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)

We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be $15.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name:	Allergy Affiliates, Inc.	Privacy Officer: John Cella, M.D.
Telephone:	941-792-4151	Fax: 941-792-8463
Email:	officemanager@allergyaffiliates.com	
Address:	6220 Manatee Avenue W, Suite 201, Bradenton, FL 34209	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Allergy Affiliates, Inc.

6220 Manatee Avenue West, Suite 201
Bradenton, FL 34209

5307 State Road 64 East
Bradenton, FL 34208

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____ _____
Signature *Date*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

_____ _____
Employee signature *Date*

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Patient' s Name: _____

Patient's DOB: _____

Notice to Patient:

By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed below. Our **Notice of Privacy Practices** provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You are entitled to a copy of this **Consent Form** after you have signed it.

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

FINANCIAL POLICIES
Revised 09-1-2013

We are pleased to serve you as your health care provider and are committed to your good health. Please understand that payment for our services is considered a part of your treatment and your obligation to us. The following is a statement of our Financial Policies which we require you to read and sign prior to treatment.

All patients must complete our Patient Registration form before seeing the doctor.
FULL PATIENT PORTION PAYMENT IS DUE AT THE TIME OF SERVICE.
WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Allergy Affiliates, Inc.
Bradenton, FL
941-792-4151

All Payments Due at Time of Service

INITIALS

The office maintains a pay at time of service policy. You need to know your insurance policy in advance to know the portion of your visit for which you will be responsible. Unpaid balances where the office must send a statement requesting payment will accrue a statement fee of $5.00 per statement for postage and/or an annual fee of $25.00. If our office is forced to utilize an outside collection agent or attorney to collect an outstanding balance, we will add an additional collection fee of 40% up to $150.00 to your account. If court fees accrue, you will be responsible for these as well. If your account accrues a credit balance, we will maintain that balance on your account and apply it to any future balance which may accrue. If a credit balance exceeds $30.00, we will refund the credit balance by check to the address on your account. Small credit balances carried forward for more than two calendar years will be adjusted. These policies are designed to comply with the Fair Debt Collection Practices Act and any applicable state laws.

Regarding Insurance

INITIALS

Regarding insurance plans where we are a participating provider, all copayments and deductibles are due prior to treatment.
We cannot bill your insurance company unless you give us timely clear and accurate insurance information. Your insurance policy is a contract between you and your insurance company—we are NOT a party to that contract. In the event we do not accept assignment of benefits, we require that you be pre-approved on an extended payment plan or provide a credit card with authorization to bill that account for any balance due. **If you have new insurance or change insurance plans, you must provide us with clear and accurate insurance information within 30 days of your visit for your insurance to be billed. If information is provided after 30 days, you will be responsible for any visits that may have occurred**. If your insurance company has not paid an office visit within 60 days, the balance may be automatically transferred to your account and you can utilize an extended payment plan. **Secondary Insurers**: We do not accept secondary insurers unless there is an automatic crossover established between the primary and secondary payers. Please ask for a copy of your visit to submit to any secondary carriers for your reimbursement if there is no established crossover.

Statements

INITIALS

We will send a statement should you have a balance with our office. If no payment is received within 30 days, an additional statement may be mailed. You will accrue late charges and postage charges for additional statements. Though we will try to remind you at each visit of any balance, it is ultimately your responsibility. When you receive an explanation of benefits from your insurance company showing any patient responsibility, you have received your first statement. Statements for copayments or deductible amounts will automatically accrue late and postage charges. There will be an additional $35 charge for checks denied by your bank and returned to the office for any reason.

Minor Patients

INITIALS

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. If a balance accrues at any time, it is your financial responsibility to arrange ahead of time to transfer copayments, coinsurance amounts, and deductibles to the parent or guardian who brings the child to the office.

Divorced Parents/Legal Custody issues

INITIALS

The adult accompanying their child to our office for an appointment is responsible for payment. Arrangements for court orders or any legal payment arrangements amongst parents must be worked out BEFORE your appointment. If a separate parent is responsible for payment, we are not a party to this arrangement. Payment is due in full at the time of appointment, and we will prepare receipt of payment for verification purposes.

Appointment Reminders and Missed Appointments

INITIALS

Your signature authorizes us to attempt to contact you 24 hours prior to your appointment with our office. We are not able to guarantee a reminder call for each visit, but we will certainly try. If you do not wish reminder calls, please notify our office in writing.

Unless canceled AT LEAST 24 HOURS IN ADVANCE, our policy is to charge the person who scheduled the appointment for missed appointments at the rate of $50.00. Please help us to serve our entire patient population best by keeping scheduled appointments. Patients who miss three or more appointments without notice may be dismissed.

Thank you for understanding our Financial Policies. Please let us know if you have any questions or concerns.

I have read, understand, and agree to these Financial Policies:

_____ _____

Signature of Patient, Parent or Guardian Signature of Patient, Parent or Guardian

_____ Date _____ Date