Allergy and Asthma Associates of Pittsburgh

One Alexander Center
2585 Freeport Road, Suite 210
Pittsburgh, PA 15238
(412)-828-3800

Richard L. Green, M.D. **Andrew G. Vayonis, M.D.** **Thomas L. Mertz, DO, PharmD**

Date: _____

-PLEASE PRINT-

Patient's Name: _____ Birth Date: _____ Age: _____

Home Address: _____
Street City State Zip Code

Home Phone Number: ( ) _____ Cell Phone Number: ( ) _____

Social Security Number: (Opt.) _____ Sex _____ Marital Status _____

Current Employment Status: _____ Full Time _____ Part Time Student Status _____ Full Time _____ Part Time

Patient's Employer or School: (Name & Address) _____

Occupation: _____ Business Number: _____

Email Address: _____

Card Holder Name: _____ Birthdate: _____ Age: _____

Home Address: _____
Street City State Zip Code

Phone: ( ) _____ Social Sec. # (Opt) _____ Sex_____ Martial Status _____

Employer Or School (Name & Address) _____

_____ Business Phone No. _____

Family Physician Name: _____ Phone: _____

Office Address: _____
Street City State Zip Code

Do You Carry Health Insurance? Yes _____ No _____

Pharmacy Name & Phone Number: _____

I hereby acknowledge that all the **information given** above is true and accurate.

X _____

Signature: Patient or Parent (If Minor)

ALLERGY AND ASTHMA ASSOCIATES OF PITTSBURGH
Adult and Pediatric Allergy, Asthma, and Clinical Immunology

Mayer Green, M.D., Founder
Richard L. Green, M.D.
Andrew G. Vayonis, M.D.
Thomas L. Mertz, D.O., PharmD.

Diplomats:
American Board of Internal Medicine
American Board of Allergy and Clinical Immunology

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Patient Consent Form (Hipaa)

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. H.I.P.A.A., the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

Allergy and Asthma Associates requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company. This also gives us permission to retrieve health information from UPMC health facilities, such as diagnostic test results. By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow us to share health information and results from tests and procedures with family members such as their spouse, parents, and others. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish your information released, please check **Yes** below and **specify which family member** (s).

You have the right to revoke this consent in writing, except where we have already made disclosures in alliance on your prior consent. **YES** ____ **NO** ____

Name (s) of individual (s) _____

_____

Authorization to Leave Message on Answering Machine

YES _____ **NO** _____

Medication Authorization

This is to give Allergy and Asthma Associates permission to obtain an active medication list through electronic prescribing of all medications taken by the patient**. YES** _____ **NO** _____

Patient Name: _____

Patient Signature: _____ **Date**: _____

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AUTHORIZATION TO BILL PATIENT INSURANCE AND PATIENT RESPONSIBILITIES

You have been referred to this office due to a specific allergy problem (asthma, sinusitis, hay fever, hives, insect sting allergy, eczema, food or drug allergies, headaches, etc.). Allergy and Asthma Associates of Pittsburgh are specialty care physicians, and we must work in conjunction with your Primary Care Physician (PCP) to provide you with your necessary medical management.

An allergic investigation includes a detailed history, physical examination, skin tests, and a thorough discussion, with all results, at the conclusion of the investigation. Any laboratory procedures, if deemed necessary (blood work and pulmonary function studies), will be completed by either our office or your PCP.

It is the **responsibility** of the **patient** to make arrangements for all **authorizations** (if one is required) once an appointment has been scheduled with Allergy and Asthma Associates of Pittsburgh.

We will submit your charges to the appropriate group for you. Any DEDUCTIBLE, CO-PAYMENT, or NONCOVERED service will be the responsibility of the patient.

If after reviewing this information, there are additional questions, please do not hesitate to contact our office.

Patient Name (print): _____

Patient Signature: _____Date:_____

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To Our Valued Patients:

We strive to provide excellent medical care to you and to all our patients. Consistent with this, we have developed appointment cancellation and no-show policies that allow us to better schedule appointments for all patients. When an appointment is scheduled, that time has been specifically reserved for you and when it is missed that time cannot be used to treat another patient in need of care. We sincerely appreciate your assistance and cooperation as this allows for a smooth office flow and more efficiently uses your time.

Our Cancellation and No-Show Policy is as follows:
We request that you please give our office at least 24-hour notice if you need to reschedule your appointment. Secondary to a substantial number of no-shows, if you do not provide us with a 24-hour notice, or if you do not show up for a scheduled appointment, you will be charged a fee of $40. A new appointment cannot be scheduled until this fee is paid in full.

Our Late Arrival Policy is as follows:
If a patient is more than 15 minutes late to their appointment with the doctor, for an injection, or testing, the appointment may be canceled and need to be rescheduled. At times, if possible, patients arriving late may be asked to wait to be seen until the provider has an opening in their schedule that day.
If you have any questions regarding these policies, please let our staff know and we will be glad to speak with you in more detail.
I have read and understand the Allergy and Asthma Associates of Pittsburgh Cancellation and No-Show Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

PRINT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____