Tottori Allergy & Asthma Associates
New Patient Adult Packet

Welcome to Tottori Allergy & Asthma Associates. Our goal is to provide the highest level of patient care while maintaining a successful and comfortable patient-physician relationship. We look forward to meeting you and taking care of all your medical needs.

Important Information For Your First Visit

- Please fill out all the paperwork, clearly print and use black pen ink only.
- Please bring your Insurance Card and a Valid Nevada I.D., we will not see any patients without both of these items.
- Please arrive at least 15 minutes prior to your visit. If you are running late, please call our office, as a late appointment may require you to reschedule your appointment.
- Please schedule appointments that are convenient and easy for you to keep. If you find that you cannot keep your scheduled appointment because of conflict or illness, please notify us at least 24 hours prior to your scheduled appointment. We will make every effort to reschedule your appointment for another time. If you are late we reserve the right to cancel your scheduled appointment and will try to see you if our schedule permits. Please call to give us at least 24 hours notice for cancellations. Failure to do so will result in a $25.00 cancellation/no show fee.
- If you are paying as a self pay (cash patient), all charges are due at the time of your appointment.
- All insurance co payments and deductibles are due at the time of your appointment. We accept Visa, Master Card, American Express, Discover, Personal Checks, Cash and Debit Cards.
- Some insurance plans require a referral from your primary care provider; it is your responsibility to obtain a referral prior to your visit. Unfortunately, we will not be able to see you if you do not have a referral at the time of your visit.
- New patient appointments may take 1-2 hours to complete. Our office is a specialist office which can have unexpected emergencies relating to our specialty, such as a trouble breather or severe allergy reaction, that may result in a delay of your appointment.
- We do not accept walk in appointments, all appointments must be made by calling our office.

If you have any questions, please feel free to contact our office at: (702) 240-4233. Thank you.

PATIENT INFORMATION (Informacion Del Paciente)

Tottori Allergy & Asthma ASSOCIATES

David H. Tottori, M.D.
Kathrina Paner, PA-C
Thomas Chu, PA-C

4000 East Charleston Blvd., Suite 100
Las Vegas, NV 89104 (702) 432-8250

9020 W. Cheyenne Ave.
Las Vegas, NV 89129 (702) 240-4233

REFERRING SOURCE: - (Origen de Referencia)

☐ Physician - *(Doctor)* _____ ☐ Phone Book - *(Directorio Telefono)*

☐ Insurance - *(Aseguranza)* _____ ☐ Other - *(Otro)*

☐ New Pt. *Nuevo* ☐ Estab. Pt. *Estaidencido*

PATIENT NUMBER

PATIENT INFORMATION

All shaded areas MUST be completed

PATIENT NAME (LAST) - *Nombre Del Paciente (Apellido)* | (FIRST) - *(Premier)* | (MI) | HOME PHONE - *(Telefono)*

ADDRESS - *(Domicilio)*

CITY. STATE - *(Ciudad/Estado)* | ZIP - *(Codigo Postal)* | D.O.B. - *(Fecha De Nacimienoto)* | SOC. SEC. # - *(Seguro Social)*

IF MINOR, NAME OF LEGAL GUARDIAN - *(Si menor nombre de guardiante)* | SOC. SEC. # - *(Seguro Social)* | EMPLOYER - *(Empleador)*

EMPLOYER ADDRESS - *(Direccion de Empleador)* | EMPLOYER PHONE

NAME OF SPOUSE (IF MINOR, NAME OF PARENT) - *(Nombre de Esposola (si Menor de Edad Nombre de Padre)* | SOC. SEC. # - *(Seguro Social)*

SPOUSE'S PLACE OF EMPLOYMENT - *(Lugar de Empleo De Esposola)* | EMPLOYER PHONE *Telefono de Trabajo*

NAME OF RELATIVE / FRIEND NOT LIVING WITH YOU - *(Nombre de Parient/Amigo que no viva con ud.)* | RELATIONSHIP - *(Parentesco)*

ADDRESS - *(Domicilio)* | PHONE - *(Telefono)*

INSURANCE INFORMATION (Please present your insurance cards / forms to the receptionist)

PRIMARY INSURANCE - *(Aseguranza Primaria)* | POLICY HOLDER - *(Asegurado)* | D.O.B. - *(Fecha De Nacimienoto)* | SOC. SEC. # - *(Seguro Social)*

ADDRESS - *(Domicilio)* | PHONE - *(Telefono)*

POLICY - *(Poliza)* | GROUP # / CERT # / CODE - *(Grupo/Cert/Codigo)*

SECONDARY INSURANCE - *(Aseguranza Secundaria)* | POLICY HOLDER - *(Asegurado)* | D.O.B. - *(Fecha De Nacimienoto)* | SOC. SEC. # - *(Seguro Social)*

ADDRESS - *(Domicilio)* | PHONE - *(Telefono)*

POLICY - *(Poliza)* | GROUP # / CERT # / CODE - *(Grupo/Cert/Codigo)*

FINANCIAL POLICY

RELEASE OF INFORMATION

By signing below, I hereby authorize Tottori Allergy & Astha Associates the right to release any medical Information necessary to file a claim with my insurance company. I further assign and direct payment(s) for all medical services under this claim to Tottori Allergy & Asthma Associates.

ASSIGNMENT OF BENEFITS/FINANCIAL STATEMENT

By signing below, I understand Tottori Allergy & Asthma Associates requires all patients and/or legal guardians of a minor patient to read and sign the financial policy prior to seeing the provider; otherwise, services may be refused. I assign benefits otherwise payable to me to be issued direct to the provider or group indicated on any claim and/or statement for services rendered. I understand that I am financially responsible for all charges for any medical service(s) rendered regardless of insurance coverage. Further, I agree to pay my deductible or any balance outstanding within 30 days of receipt of statement.

I understand that it is my responsibility to know my insurance benefits at the time of service(s), including but not limited to "out of pocket expenses" i.e.: co-pay(s), deductible, skin or lung function testing, vaccination(s) and immunotherapy. I understand this office may not provide me with the "out of pocket expenses" associated with services at the time of service: if desired a written request for any service may be provided to me prior to any service rendered and I have the right to refuse a service for any reason.

I understand it is my responsibility to inform the provider of any changes relative to my current insurance coverage and provide their office with copies of my insurance cards and/or claim forms (if required) by my insurance company. I understand accounts will be considered delinquent after 90 days. Delinquent accounts will be placed with a private collection agency and will be subject to all reasonable collection/court cost.

Cash Patients: Payment is due "In Full" at the time services are rendered.
Insured Patients: Co-pay(s), deductibles and co-insurance fees are due at the time services are rendered.

By signing below, I acknowledge I have read and fully understand Tottori Allergy & Asthma Associates financial policy.

Signature *(Firma)* _____ Date *(Fecha)* _____

All shaded areas MUST be completed

Allergy History

Condfidential Record: Information will not be relesed unless authorized by you.

David H. Tottori, M.D.
Kathrina Paner, PA-C
Thomas Chu, PA-C

Tottori Allergy & Asthma ASSOCIATES

4000 East Charleston, Suite 100
Las Vegas, NV 89104 • (702) 432-8250

9020 W. Cheyenne Avenue
Las Vegas, NV 89129 • (702) 240-4233

Last Name: First Name: Middle Name or Initial:

Address: City: State: Zip:

Home Phone Number: Work Phone Number: Referred By: Birth Date: Month Day Year

Marital Status: S M D W (Please circle one) Today's Date:

Patient: Please fill out this side:

Physician Notes:

The main problems for coming here are:

	YES	NO
Nasal congestion or runny nose	☐	☐
Itchy or watery eyes	☐	☐
Sneezing	☐	☐
Snoring or breathing through the mouth	☐	☐
Drainage down the throat	☐	☐
Frequent yellow or green nasal drainage	☐	☐

Transfer of allergy care from Dr.

Continuation of allergy shots started. years ago

Coughing	☐	☐
Wheezing or shortness of breath	☐	☐

Diagnosis of asthma made years ago

Number of past hospitalizations for asthma:

Number of past emergency visits for asthma:

Days of school or work missed in past year:

Possible reaction to (food or drug):

Bee sting reactions	☐	☐
Rashes	☐	☐
Frequent infections	☐	☐

Number of ear infections in the past year:

Number of sinus infections in the past year:

Number of pneumonias during lifetime:

Headaches	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐

Other (explain): _____

These symptoms occur:

Spring ☐ Summer ☐ Fall ☐ Winter ☐

Days or weeks at a time ☐ All the time ☐

At home ☐ Room: _____

Worse outdoors ☐ At work or school ☐

During the day ☐ Worse at night or morning ☐

Symptoms are made worse by:

- ☐ Colds
- ☐ Cold Air
- ☐ Heat
- ☐ Trees
- ☐ Grass
- ☐ Weeds
- ☐ Exercise
- ☐ Alcohol
- ☐ Aspirin
- ☐ Air Conditioning
- ☐ Air Pollution
- ☐ Sunlight
- ☐ Tobacco Smoke
- ☐ Dogs
- ☐ Cats
- ☐ Mold
- ☐ Dampness
- ☐ Increased Humidity
- ☐ Sprays/Cleaning Agents
- ☐ Dust
- ☐ Wind
- ☐ Weather Changes
- ☐ Perfumes/Scents
- ☐ Other animals
- ☐ Foods
- ☐
- ☐

Physician Notes:

Previous allergy or asthma medications (incl. OTC):

List Antihistamines, Antibiotics, Theophylline/Bronchodilators, Steroids (Prednisone), Nose Drops, Etc.

	☐ helped	☐ no help	☐ drowsy	☐ jittery	☐ Duration	
	☐ helped	☐ no help	☐ drowsy	☐ jittery	☐ Duration	
	☐ helped	☐ no help	☐ drowsy	☐ jittery	☐ Duration	
	☐ helped	☐ no help	☐ drowsy	☐ jittery	☐ Duration	

All current medicines:

	number of mg. tabs, caps, or inhaler puffs	
		times per day
		times per day
		times per day
		times per day
		times per day
		times per day
		times per day

Mark an "X" in front of any medications above taken within the last 12 hours.

Current Environment (✓ if present):

Where is most of your time spent? ☐ House ☐ Apt. ☐ Office ☐ School ☐ Outside ☐ Other

Do you live in a ☐ House ☐ Apt. ☐ Mobile Home ☐ Split between homes

Type of heat at home; ☐ gas ☐ electric

Type of air conditioning at home; ☐ forced air ☐ evaporative cooler

How often do you change filters?

Does anyone at home smoke? ☐ Yes ☐ No; How many people?

Do you have a humidifier? ☐ Yes ☐ No; ☐ Portable ☐ Central

Are you using oxygen at home? ☐ Yes ☐ No

Floor; ☐ Area rugs ☐ Wall to wall carpet ☐ Linoleum

Windows; ☐ Drapes ☐ Curtains ☐ Shades ☐ Blinds

Bedding; ☐ Mattress & box springs ☐ Waterbed

Pillows; ☐ Foam Rubber ☐ Feather ☐ Polyester

Animals; Type of pet(s) ☐ Dogs ☐ Cats ☐ Birds ☐ Other

Where does the pet sleep?

Check any below that apply:

☐ Cigarette smoke ☐ Lots of houseplants ☐ Feather pillow

☐ Air cleaner ☐ Down comforter ☐ Improvement on trips

Social History:

Parents of the patients are:
- ☐ divorced
- ☐ separated
- ☐ one is deceased
- ☐ both are deceased
- ☐ none of the above

Current occupation is:

Past occupations: (example, cab driver 1950-1970)

Level of education:

ALCOHOL/DRUGS:

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes;
- ☐ Daily
- ☐ No more than three days per week
- ☐ Less than once per week
- ☐ Has anyone in your family objected to the amount you drink?

Do you use other drugs? ☐ Yes ☐ No

LIST HOBBIES AND SPORTS:

State you were born in

Year you moved to Nevada if not born here

Past Medical History:

	Age or Year	Hospitalization	Surgery
Appendectomy		☐	☐
Arthritis		☐	☐
Brain Surgery		☐	☐
Broken Bones		☐	☐
Cancer Surgery		☐	☐
Diabetes		☐	☐
Gall Bladder Disease		☐	☐
Glaucoma		☐	☐
Head Injury		☐	☐
Heart Disease		☐	☐
Hepatitis		☐	☐
High Blood Pressure		☐	☐
Hysterectomy		☐	☐
Kidney Stones		☐	☐
Peptic Ulcers		☐	☐
Thyroid Disease		☐	☐
Tonsillectomy		☐	☐
Other		☐	☐

Emergency Visits: times in past year

times in past five years

DRUG ALLERGIES:

- ☐ Aspirin
- ☐ Nose Drops
- ☐ Laxatives
- ☐ Sedatives
- ☐ Tonics
- ☐ Antitoxins
- ☐ Vitamins
- ☐ Sulfa drugs
- ☐ Penicillin
- ☐ "Mycins"
- ☐ Other Antibiotics
- ☐ Hormones
- ☐ Nerve medicines
- ☐ Antihistamines
- ☐ Steroid drugs like Cortisone/Prednisone
- ☐ Others

If yes, give details/reactions:

Immunization Adverse Reactions:

caused

caused

Symptom

Physician Notes:

Family History:

Utilize space to the right if needed.

First Names	Allergies	Asthma	Frequent coughing	Frequent infections	Deceased	Age at death	Cause
Father:	☐	☐	☐	☐	☐		
Mother	☐	☐	☐	☐	☐		
Brothers/Sisters:	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		

Other chronic conditions such as cystic fibrosis, emphysema, bleeding tendency, cancer, diabetes, hay fever, high blood pressure, leukemia, stroke, tuberculosis, recurrent hives or swelling, lupus, rheumatoid arthritis, etc.

Review of Systems: (check if present)

- ☐ fever
- ☐ weight loss/weight gain; how much
- ☐ skin problems, besides eczema
- ☐ joint swelling, pain, or stiffness; where
- ☐ blood count problems (anemia, etc.)
- ☐ eye problems (explain)
- ☐ throat infections
- ☐ stomach upset
- ☐ nerve or psychiatric problems
- ☐ hormone problems (such as hot flashes, etc.)
- ☐ tired or worn out
- ☐ poor appetite
- ☐ backpain
- ☐ leg or foot pain when walking
- ☐ hearing problems
- ☐ chest pain or tightness when not having trouble breathing
- ☐ abnormal electrocardiogram
- ☐ foot or ankle swelling
- ☐ fast or irregular heart beat; give details
- ☐ food reactions that causes pain, nausea or upset; details
- ☐ trouble swallowing
- ☐ indigestion or heartburn ☐ daytime ☐ nighttime
- ☐ vomiting blood
- ☐ change in bowel movements
- ☐ constipation
- ☐ frequent loose stools or diarrhea
- ☐ black or tarry stools
- ☐ taking laxatives
- ☐ trouble passing water
- ☐ nighttime urination; how many times per night
- ☐ losing urine when you cough or sneeze
- ☐ blood or pus in urine
- ☐ weakness of arm or leg for short time
- ☐ any convulsions or fits
- ☐ Women: When was last Pap Smear

Name of person filling out this history form (print):

Relationship if not the patient:

Physician Notes:

Tottori Allergy & Asthma Associates

Skin testing may be required on your initial visit. At times, medications containing antihistamines may interfere with testing results. IF POSSIBLE, please do not take any antihistamines 3 days prior to your visit. If you are not able to stop your antihistamines prior to your visit, please inform the nurse at the time of your visit.

PLEASE DO NOT STOP ANY OF YOUR REGULAR MEDICATIONS!!!!

Below are some examples of typical medications which contain antihistamines:

☐ Actifed	☐ Night Time Sleep Aid
☐ Advil PM, Advil Allergy, Advil Cold/Sinus	☐ Norel SR/DM
☐ Ala-Hist	☐ Nytol
☐ Alavert- All Forms	☐ Nyquil
☐ Aleve Cold	☐ Patanase Nasal Spray
☐ Alka Seltzer Plus/Cold	☐ Pediacare
☐ Allegra- All Forms	☐ Percogesic
☐ Allerest	☐ Periactin
☐ AlleRx- All Forms	☐ Phenergan- All Forms
☐ Allergy Relief Med	☐ Phenylephrine HCL
☐ Asteline Spray (Azelastine)	☐ Phenothiazines
☐ Astepro Spray	☐ Phenyltoloxamine
☐ Atarax/Vistaril	☐ Polyhistine- All Forms
☐ BC Cold Powder	☐ Promethazine HCL
☐ Benadryl	☐ Robitussin- Many Forms
☐ Benylin Cough Med	☐ Rondec
☐ Bromfed- All Forms	☐ Rynatan/ R-Tannate
☐ Brompheniramine Maleate	☐ Sinutab
☐ Carbinoxamine	☐ Sominex
☐ Cetirizine HCL	☐ Sudafed Cold and Allergy
☐ Chlorpheniramine Maleate	☐ Tagamet
☐ Chlor-Trimeton- All Forms	☐ Tanafed
☐ Clarinex- All Forms	☐ Theraflu- All Forms
☐ Claritin- All Forms	☐ Time-Hist
☐ Comtrex	☐ Triaminic- All Forms
☐ Contac- All Forms	☐ Tussionex
☐ Coricidin	☐ Tylenol Cold/Sinus/Allergy/Sleep
☐ Co-Tylenol	☐ Vistaril
☐ Cough Meds with Antihistamines	☐ Vicks 44M
☐ Cyproheptadine	☐ Xyzal- All Forms
☐ Dimetane	☐ Zantac
☐ Dimetapp	☐ Zicam
☐ Diphenhydramine HCL- Check Label	
☐ Dramamine	
☐ Drixoral	
☐ Dymista	
☐ Excedrin PM	
☐ Extendryl	
☐ Fexofenadine- All Forms	
☐ Hydroxyzine Pamoate/HCL	
☐ Loratadine	
☐ MylantaAR	

Tottori Allergy & Asthma ASSOCIATES

PATIENT ACKNOWLEDGMENT - SERVICE ANIMALS

Patient Name: _____

Date of Birth: _____

I am the patient or the patients' representative with legal authority to execute this Acknowledgement on behalf of the patient. I understand that Tottori Allergy & Asthma Associates has adopted a policy regarding service animals to provide a reasonable accommodation to people with disabilities who utilize service animals. In accordance with such policy and applicable laws and regulations, service animals may be present in the practice's facility. I acknowledge and understand that I may encounter service animals or pet dander in the facility, and that the practice has made available a copy of its service animal policy to me upon request.

I have decided to seek care at the practice, being informed that I may encounter service animals or pet dander which could prompt a systemic reaction. I understand that such a reaction is rare, but can be life-threatening, and that if I have unstable asthma or am extremely sensitive to the allergens, I may have a higher chance of developing a reaction.

If you have any questions about your treatment for allergies and/or asthma, please contact Manny Testa/Administrator at 702-240-4233.

I have read and acknowledge that the above statements are true and correct, and that any questions I have about service animals at the practice have been answered satisfactorily. I certify that I am a competent adult of at least 18 years of age.

"Please notify our office prior to your appointment if you utilize a service animal so that we may make accommodations to assist you, while also safeguarding the health and safety of others in our offices, many of whom are asthmatic and/or severely allergic to pet dander."

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

HIPAA Notice of Privacy Practices

David H. Tottori, M.D.
Kathrina Paner, PA-C
Thomas Chu, PA-C

4000 East Charleston Blvd., Suite 100
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Las Vegas, NV 89129 • (702) 240-4233

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 of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operation and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present, future physical or mental health condition and related health care services. We are required by law to: (i) maintain the privacy of your Protected Health Information; (ii) give you this notice of our legal duties and privacy practices regarding health information about you; and (iii) follow the terms of our notice that is currently in effect.

We reserve the right to change the terms of this notice and to make the new provisions effective for all Protected Health Information that we maintain. Any revisions made to this notice will be immediately posted in our front office lobby area. We will also inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may be asked to sign a revised version at the time of your next appointment.

1. Uses and Disclosure of Protected Health Information

The following describes the ways we may use and disclose your Protected Health Information.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: We may use or disclose your Protected Health Information to obtain payment for your health care services. For example, we may give your health plan information about you so that they will pay for your treatment.

Healthcare Operations: We may use or disclose your Protected Health Information in order to support the business activities of our practice. These uses and disclosures are necessary to ensure that all of our patients receive quality care and to operate and manage our office. For example, we may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information.

Appointment Reminders: We may use and disclose your Protected Health Information to contact you to remind you of your appointment or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law: We may use or disclose your Protected Health Information if state or Federal law requires it, including in the following situations pursuant to applicable laws and regulations: Public Health issues; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Medical Examiners and Funeral Directors; Organ Donation; Threats to Health and Safety; Military Activity and National Security; Workers' Compensation; and with respect to Inmates. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Research: We may disclose your Protected Health Information for research when such research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information. We may also share your Protected Health Information with people preparing to conduct a research project.

Fundraising: Under certain circumstances, we may contact you regarding fundraising efforts. At this time, you will also be provided an option for you to elect not to receive further fundraising communications.

Family Members/Certain Third Parties: You have the right and choice to tell us to share your Protected Health Information with a person who is involved in you medical care or payment for your care, such as your family or a close friend, or in the event of a disaster relief effort. If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest.

2. Uses and Disclosures Where Authorization is Required

Psychotherapy Notes: Unless otherwise required by law, most disclosures of psychotherapy notes (if recorded by us) will require your authorization.

Sale of Protected Health Information: Other than the transition provisions in 45 C.F.R. 164.532, we will obtain your authorization for any disclosure of your Protected Health Information for sale. Such authorization will state whether the disclosure will result in remuneration.

Marketing: Except in limited situations permitted under 45 C.F.R. 164.508(a)(3), we will obtain your authorization for any use or disclosure of your Protected Health Information for marketing purposes. Such authorization will state whether remuneration was involved.

Other Permitted and Required Uses and Disclosures: Other disclosures not described in this notice will be made only with your individual written authorization, unless required by law. You may revoke such authorization, at any time, in writing to our Privacy Officer identified below, except to the extent we have taken an action in reliance on the use or disclosure indicated in the authorization.

3. Notice to Patients Regarding the Destruction of Health Care Records

In accordance with Nevada law, Tottori Allergy & Asthma Associates hereby advises all patients of our company's commitment to comply with Nevada law regarding the destruction of health care records as follows:

1.) The health care records of a person who is less than 23 years of age may not be destroyed; and
2.) The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and
3.) Except as otherwise provided in subsection 7 of NRS 629.051 and unless a longer period is provided by federal law or pursuant to your insurance plan, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.
Please be advised your medical records may be requested from our company by filing a "Medical Records Release Form" located in the front office. We will process the request in a reasonable period of time (not to exceed 1-2 weeks) and reserve the right to charge $0.60 per page for filing such request.

4. Your Rights

The following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect, access and request a copy of your Protected Health Information: You have the right to inspect, access and request a copy of your Protected Health Information, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and Protected Health Information that is now subject to law that prohibits access to Protected Health Information. You may elect to receive your Protected Health Information in which ever requested form you choose. For example, you may receive your Protected Health Information by an electronic format, by mail, by email or request a hard copy. If you elect to receive your Protected Health Information electronically, we will provide your Protected Health Information in a readily producible format per your request. Please note, if you wish to have your Protected Health Information by email, we may use an encrypted email to avoid risks associated with unencrypted emails, such as viruses or theft. You have the right to request an unencrypted email, but understand and agree to accept the risks associated with unencrypted emails. You have the right to request your Protected Health Information be transmitted to a third party. All request, must be submitted in writing to our Privacy Officer and will be timely processed from the date received in accordance with law. We reserve the right to charge $0.60 per page for a hard copy of your information and a reasonable cost for copies of X-ray photographs and other healthcare records produced by similar processes.

You have the right to request a restriction of your Protected Health Information: This means you may ask us not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. You then have the right to use another healthcare professional. In addition, Tottori Allergy & Asthma Associates may decide to deny access to medical records in limited circumstances, please contact our Privacy Officer for further details.

You have a right to be told of a breach: We will timely notify you in writing following any breach of your unsecured Protected Health Information, as required by law. You have the right to restrict certain health plan disclosures: You have the right to restrict certain disclosure of your Protected Health Information to a health plan with respect to payment of health care items or services for which you have paid out-of pocket and in full for a health care item or service, unless required by law. All request for restrictions, must be submitted in writing to our Privacy Officer and will be timely processed from the date received in accordance with law.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location: All requests to receive confidential communications by alternative means or at an alternate location must be authorized by you in writing. Your request will be timely processed from the date received in accordance with law.

You have the right to obtain a paper copy of this notice from us: You may request a paper copy of this notice on or after the effective date of this notice revision, even if you have agreed to this notice alternatively, i.e., electronically.

You have the right to have your physician amend your Protected Health Information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information: You have the right to an accounting of disclosures except for those related to treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make).

5. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated by our office. You may file a complaint to the U.S. Department of Health and Human Services Office for Civil Rights. Complaints may be in writing, either **electronically via the OCR Complaint Portal**, or on paper by mail, fax, or **e-mail**; please see the following contact information:

Email: OCRComplaint@hhs.gov
Region IX - San Francisco (American Samoa, Arizona, California, Guam, Hawaii, Nevada)
Michael Leoz, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697

To file a written complaint to our office, please see the following contact information:
Tottori Allergy & Asthma Associates
Attention: HIPAA Privacy Officer
9020 W. Cheyenne Ave Las Vegas, NV 89129
Voice Phone (702) 240-4233
FAX (702) 242-5901

We will not retaliate against you for filing a complaint.

This notice was published and is effective on **September 23, 2013**.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice of Privacy Practices, currently in effect. For further information about matters covered by this notice or if you have any objections to this notice, you may ask to speak with our HIPAA Compliance Officer (Manuel Testa/Administrator) in person or by phone at : (702) 240-4233.

Signature below is only acknowledgment that you have received and fully understand this Notice of our Privacy Practices:

Printed Name of Patient:_____ Signature of Patient/Parent/Guardian or Authorized Representative_____

Printed Name of Patient/Parent/Guardian or Authorized Representative (if applicable)_____ Date_____

TOTTORI ALLERGY & ASTHMA ASSOCIATES
AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

☐ **STAT REQUEST**

Facility Name/Provider: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City/State/Zip: _____

Below listed patient and/or guardian authorizes the following healthcare facility to make record disclosure

Patient Name: _____ **Date of Birth:** _____

Phone (H): _____ **Phone (W):** _____

Address: _____ **City/State/Zip:** _____

Dates and Type of Information to Disclose:

☐ Entire Medical Records
☐ Dates (Other): _____

I am authorizing the following information be disclosed:

Check all that apply:

☐ HIV/AIDS
☐ DRUG/ALCOHOL ABUSE/TREATMENT
☐ MENTAL/BEHAVIORAL HEALTH CONDITIONS

The Purpose of Disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care
☐ Referral/Other: _____

This information may be disclosed and used by the following individual or organization:

Send/Release Records To: _____

Address: _____

City/State/Zip: _____ **Phone:** _____ **Fax:** _____

Right to Revoke This Authorization: I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to this healthcare provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ f I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

Right to Refuse to Sign This Authorization: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. **Right to Receive to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed:** I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. **Right to Receive a Copy of This Authorization:** I understand that if I agree to this authorization, I may receive a copy. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office authorized individual or origination making disclosure. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State Laws and a list of those persons/organizations is available upon request. **Copy, Electronic or Facsimile (Fax) Valid as an Original.**

I have read the above foregoing Authorization for Release of Information and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative — **Date**

_____ _____

Printed Name of Authorized Representative — Relationship/Capacity to Patient

_____

Address and Telephone Number of Authorized Representative

TOTTORI ALLERGY & ASTHMA ASSOCIATES

9020 W. Cheyenne Ave
Las Vegas, NV 89129
Phone: (702) 240-4233
Fax: (702) 242-5901

4000 E. Charleston Blvd. Ste. 100
Las Vegas, NV 89104
Phone: (702) 432-8250
Fax: (702) 432-8011

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____

Phone (H): _____ **Phone (W):** _____

Address: _____ **City/State/Zip:** _____

☐ **Dates and Type of Information to Disclose:**
Entire Medical Records
Dates (Other): _____

☐ **The Purpose of Disclosure is:**
Change of Insurance or Physician
Continuation of Care
Referral/Other: _____

☐ **I authorize the following information be disclosed**:
HIV/AIDS
DRUG/ALCOHOL ABUSE/TREATMENT
MENTAL/BEHAVIORAL HEALTH CONDITIONS

LIST ANY FAMILY MEMBER OR PERSON WHO YOU AUTHORIZE TO ACCESS YOUR MEDICAL RECORD

Release To: _____

Address: _____

City/State/Zip: _____ **Phone:** _____ **Fax:** _____

I have read the above foregoing Authorization for Release of Information and do herby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative **Date**

_____ _____
Printed Name of Authorized Representative Relationship/Capacity to Patient

_____
Address and Telephone Number of Authorized Representative

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. Above listed patient and/or guardian authorizes the following healthcare facility to make record disclosure. Please Note: Copy fee of $.35 per page may be charged for copies

Right to Revoke This Authorization: I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to this healthcare provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

Right to Refuse to Sign This Authorization: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. **Right to Receive to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed:** I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. **Right to Receive a Copy of This Authorization:** I understand that if I agree to this authorization, I may receive a copy. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office authorized individual or origination making disclosure. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State Laws and a list of those persons/organizations is available upon request. **Copy, Electronic or Facsimile (Fax) Valid as an Original.**