Charleston Allergy & Asthma

Bruce D. Ball, MD · Andrew E. Davidson, MD · Jeffrey J. Dietrich, MD · Thomas B. Harper, III, MD

Meredith L. Moore, MD · Carolyn R. Word, MD · Lindsey Stoltz Steadman, MD

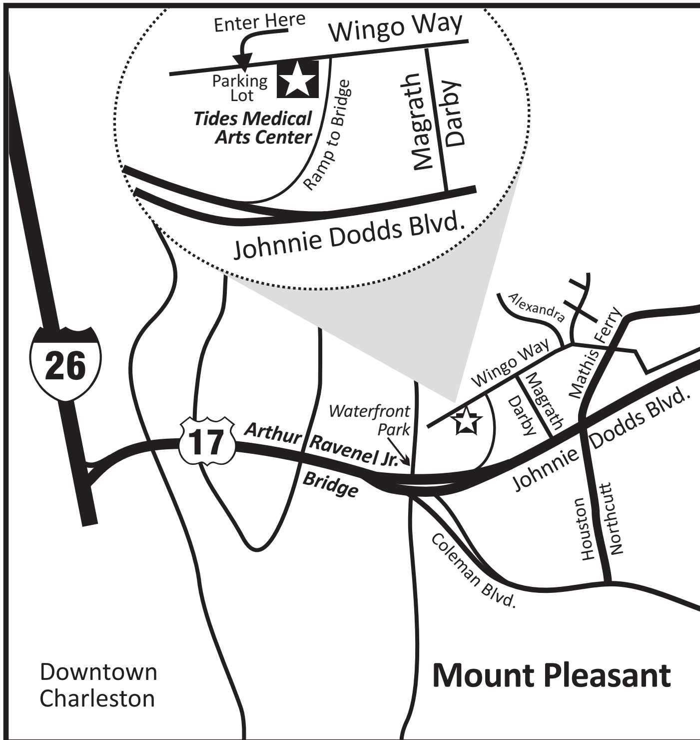
________________________________ has an appointment on

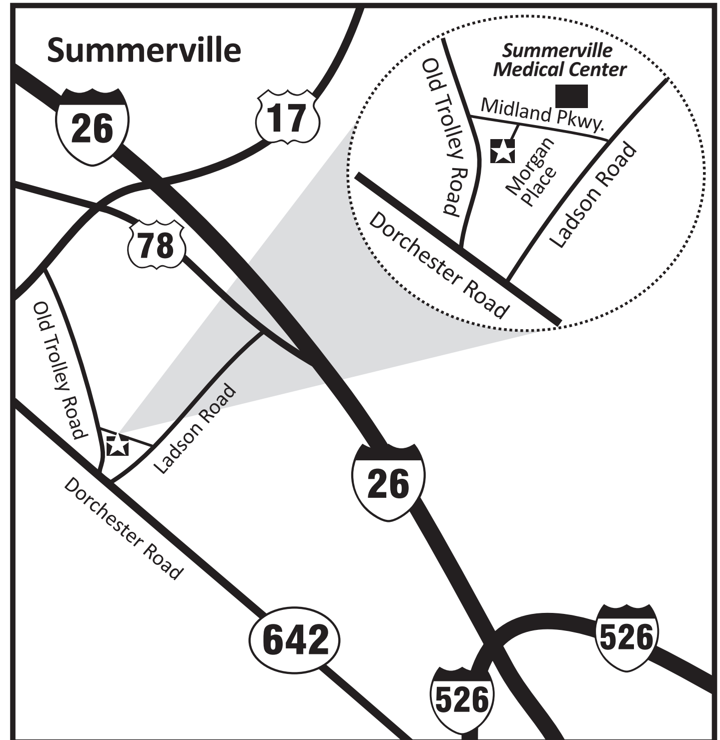
☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri Date ______________ at ______________

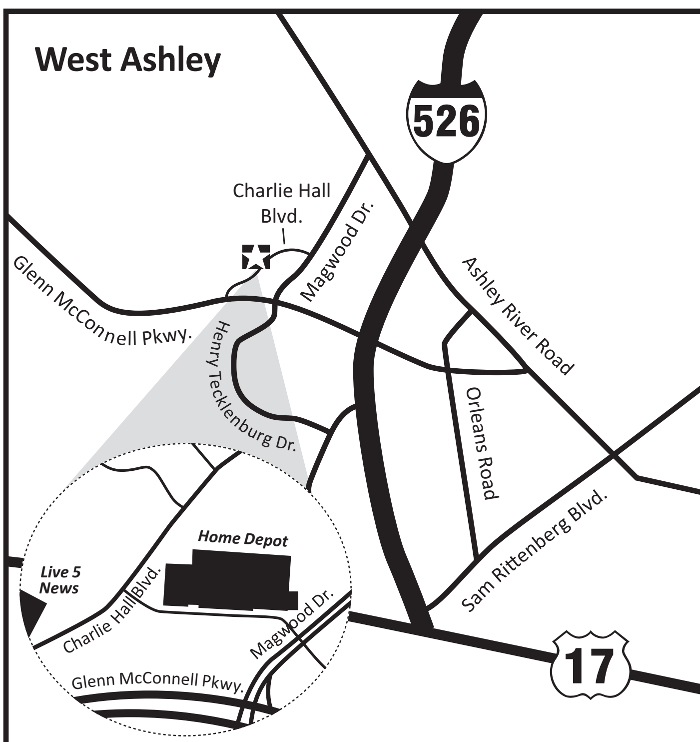
☐ 180 Wingo Way, Suite 102, Mount Pleasant, SC 29464 • Phone (843) 881-2030 • Fax (843) 881-6249

☐ 102 Morgan Place, Summerville, SC 29485 • Phone (843) 832-9588 • Fax (843) 486-5500

☐ 2090 Charlie Hall Blvd, Suite 301, Charleston, SC 29414 • Phone (843) 556-9588 • Fax (843) 556-6855







DIRECTIONS:

Mount Pleasant Office – 180 Wingo Way, Suite 102
From Mount Pleasant: Highway 17 South toward the Ravenel Bridge. Turn right at Magrath Darby Blvd (light after Mathis Ferry Road). At stop sign, turn left. Go past median in road. The Tides Medical Arts Center building is on the left.

From Charleston: Highway 17 North over the Ravenel Bridge. Turn left at first traffic light (Magrath Darby Blvd). At stop sign, turn left. Go past median in road. The Tides Medical Arts Center building is on the left.

Summerville Office – 102 Morgan Place
Off Old Trolley Road, turn at the Burger King. We are located in the first cul-de-sac on the right. We are located off of Midland Parkway near Summerville Medical Center.

From I-26: take Exit 205A, turn left onto Ladson Rd, Turn right onto Midland Pkwy. We are located in the second cul-de-sac on the left past Summerville Medical Center.

West Ashley Office – 2090 Charlie Hall Blvd, Suite 301
From I-526: Take Exit 11B-North toward hospital on Paul Cantrell/Glenn McConnell Pkwy. Continue through intersection of Glenn McConnell/Magwood Drive. Turn right onto Charlie Hall Blvd. We are the fourth building on the left.

From I-26: Take Cosgrove Ave., Exit 216A. At the second light, bare right and take Highway 7 (Sam Rittenberg Blvd). Turn right onto Highway 61 and stay left. Continue under I-526 underpass, go through Magwood Drive intersection. Turn right onto Charlie Hall Blvd. We are the fourth building on the left.

Charleston Allergy & Asthma
Patient Information

DATE: ______________________ PCP/REFERRING PHYSICIAN: ____

PATIENT'S FULL NAME: ____

STREET ADDRESS: ____

CITY,STATE,ZIP:____

MAILING ADDRESS (PO BOX):____________CITY,STATE,ZIP:____

PHONE: (Home) ______________________ (Cell) _______________________ (Work) ____________________________

BIRTHDATE: __________________SEX:__________RACE:__________MARITAL STATUS: ____________________________

EMPLOYER: ____PHONE:__________________________________

PLEASE **CIRCLE** YOUR PREFERRED METHOD OF CONTACT: **HOME / CELL / TEXT**

PHARMACY NAME: _________________________________ **PHARMACY PHONE:** _______________________________

INSURANCE PREFERRED LABRATORY: ____

COMPLETE THIS SECTION ONLY IF PATIENT IS A CHILD

RESPONSIBLE PARTY: ____RELATIONSHIP___________________________

MAILING ADDRESS (IF DIFFERENT):____

CITY,STATE,ZIP:____

PHONE: (HOME) ____________________ (CELL)______________________

BIRTHDATE: ______________________SEX:___________RACE:__________MARITAL STATUS: ________________________

EMPLOYER: ____PHONE:__________________________________

EMERGENCY CONTACT: ________________________________RELATIONSHIP:_____________________________________

ADDRESS: ____

PHONE: (HOME) _________________________________ (CELL) ____

PRIMARY INSURANCE INFORMATION – *WE REQUIRE A COPY OF YOUR INSURANCE CARD AT THE TIME OF YOUR APPOINTMENT AND AT EACH VISIT. YOU NEED TO CONTACT YOUR PRIMARY CARE PHYSICIAN IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL TO THIS PRACTICE.*

NAME OF INSURED: ____**BIRTHDATE**:_________________________________
(**PRIMARY HOLDER OF THE INSURANCE POLICY**)

INSURED'S SOCIAL SECURITY NUMBER: ____

NAME OF INSURANCE COMPANY: ____

PHONE#:_________________________POLICY#:__________________________________GROUP#:____________________

EMPLOYER: ____PHONE#:_________________________________

SECONDARY INSURANCE INFORMATION **(PRIMARY HOLDER OF THE INSURANCE POLICY)**

NAME OF INSURED: ____**BIRTHDATE**:_________________________________

INSURED'S SOCIAL SECURITY NUMBER: ____

NAME OF INSURANCE COMPANY: ____

PHONE#:______________________________POLICY #:______________________________GROUP #:___________________

EMPLOYER: ____PHONE#:_________________________________

PLEASE READ AND COMPLETE THE INFORMATION ON THE NEXT PAGE.

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask us any questions regarding our fees or your responsibility. Our Financial Policy will be provided for your signature and a copy will be made available to you upon request.

We participate with most major insurance companies. You may contact your insurance company prior to your initial visit to verify participation, copay, and benefits. As a courtesy, we will file the charges for your visits with your insurance company. You will be responsible for copay and deductibles. **Deductibles and copays are expected at the time services are rendered as designated by your insurance company. Please see our Financial Policy.**

I understand I will provide a copy of my insurance card(s) at the time of my initial visit and any additional visits. If for any reason I do not have my insurance card(s) in my possession, I will be responsible for payment in full of the visit at the time of service.

I further understand, if my insurance company requires a referral from my primary care physician, and I have not contacted the primary care physician for the referral, I will be responsible for payment of the visit at the time of service.

I authorize the release of my medical information necessary for treatment and/or to process my claims with Charleston Allergy & Asthma. I also authorize payment of medical benefits, including secondary insurance, directly to Charleston Allergy & Asthma for services rendered should Charleston Allergy & Asthma file for same.

Patients who fail to keep their appointment or do not call with **two** hours' notice will be considered a **"No Show"** and may be charged an insufficient notice fee of **$15** on the **third** event. On the **fourth** event within a 12-month period, the patient may be subject to **$30** insufficient notice fee and may be dismissed from the practice. Exceptions may be made at the discretion of the office staff in the case of inclement weather and/or patient circumstances.

***Your visit may include in-office testing for allergies and/or breathing tests, fees for these tests are not included in the office visit charge. ***

I am aware that if I have a deductible and/or a co-pay designated by my insurance company, I will be responsible for payment of that deductible and/or co-pay at the time of my service(s).

____ Date: _______________________________
Signature of Patient/Parent/Guarantor

Charleston Allergy & Asthma is excited to offer you the ability to access your medical records, as well as, interact with our office online through our Patient Portal. Once you are signed on to the Patient Portal, you will have the ability to **request and reschedule appointments**, **request prescription refills**, **send and receive messages** from our staff, **access and review lab results**, **update your information, review and request your medical records**, as well as, **review current and past billing statements**. All of these features are easily accessible anywhere you have internet access. Our web portal is encrypted and offers the best security obtainable. All we need is an email address accessible only by you (or someone you have authorized to use this email).

Please keep your password safe and do not share it with anyone you do not wish to view your medical record. **For more detailed information, please ask the front desk for a brochure**.

__________________________________Email Address: ____________________________________
Patient Name
____Date:_______________________________
Signature of Patient/Parent/Representative 10/19

Charleston Allergy & Asthma

Financial Policy

Thank You for choosing our practice. We are committed to providing you with quality and affordable healthcare. The following information answers frequently asked questions regarding patient and insurance responsibility for services rendered during your visit. Feel free to ask us any questions and sign in the space provided. A copy will be provided to you upon request.
Thanks so much for being our patient!

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

SELF PAY (NO INSURANCE): You will be required to pay in full at the time of service. New patients are required to pay $250.00 at the initial visit, all or part of this will be for the office visit only. There are additional charges for any testing (allergy or pulmonary). We will have a member of the business office discuss the cost of additional charges before we perform any testing. Additional testing will be performed as determined by the rendering physician at the time of the office visit.

INSURANCE: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and dictates the amount due by the patient. You need to contact your insurance company to verify participation, benefits, and copay. If your insurance company informs us you are ineligible for benefits, you will be considered **self pay** (no insurance), see above, or you can reschedule your visit.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. You will need to contact them if you disagree with their determination on the payment of your claim.

REFERRALS: Some insurance plans, with which we are contracted, require a referral authorization from your primary care physician or pediatrician. If we have not received a referral prior to your arrival at our office, you may call your referring physician from our office to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

CO-PAYMENTS AND DEDUCTIBLE: All co-payments, deductible, and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your deductible has not been met, we expect for you to pay 40% of your services at the time of your visit.

PROOF OF INSURANCE / COVERAGE CHANGES: All patients must complete our Patient Information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with this information in a timely manner, you may be responsible for the balance on your account. Some insurance companies will deny charges if filed later than 90 days after the date of service.

METHODS OF PAYMENT: We accept payment by Cash, Check, Debit/Credit Cards, HSA cards, Cashier or Certified Check, Money Orders.

PATIENT STATEMENTS: If you have an unpaid balance, you will receive a statement monthly by mail. Statements are also available on-line through the Patient Portal. The statement is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to our internal collection department and/or may be submitted to an outside collection agency with possible dismissal from the practice.

PAYMENT PLANS: We offer convenient, affordable payment plans for our in-house accounts (minimum $25 monthly payment). Please see our business office team for details.

COLLECTION FEES: Accounts submitted to the collection agency are not eligible for payment plans. All collection costs (approximately one third of the submitted balance) may be charged back to the account. Patients referred to the collection agency will be required to have prior approval before your visit is scheduled.

RETURNED CHECKS: Your account will be charged a $25.00 service fee for checks not honored by your bank. The check and service fee must be paid in full before your next visit.

I have read, understand, and will comply with the terms of your financial policy.

PATIENT'S NAME: ____________________ DATE OF BIRTH: ____________________

RESPONSIBLE PARTY: ____________________ SSN OF RESPONSIBLE PARTY: ____________________

SIGNATURE: ____________________ DATE: ____________________

Charleston Allergy & Asthma

WHAT TO EXPECT AT YOUR FIRST VISIT

Your allergy evaluation will consist of **two separate appointments.** Your first visit will be a history and physical with the doctor, skin testing, ordering labs and x-rays if needed, and medications, if ordered. You will return for a summary conference on a later date to discuss the results and treatment **after all test results are compiled.**

MEDICATIONS THAT INTERFERE WITH ALLERGY SKIN TESTING

In order to ensure the most valid results of your allergy work-up, we request that you refrain from taking the following medications during the period indicated.

******Do not take any antihistamines or cold preparations 5 - 7 days prior to your appointment. ******

There are many drugs, which include antihistamines. Some of the more common ones are:

Alavert
Alaway Eye Drop
Allegra
Alka-Seltzer Cold
Amitriptyline
Astelin Nasal Spray*
Astepro Nasal Spray*
Atarax*
Atrohist
Azelastine*
Benadryl
Bepreve Eye Drops
Bromfed
Brompheniramine
Carbinoxamine
Cetirizine*
Chlorpheniramine
Chlor-Trimeton (CTM)
Clarinex
Claritin
Comhist
Comtrex
Contact
Cyproheptadine
Deconamine
Desloratadine
Dimetapp
Diphenhydramine
Dramamine
Dristan
Drixoral
Dymista*
Elestat Eye Drop
Epinastine Eye Drop
Fexofenadine
Hydroxyzine*
Histex
Karbinal
Ketotifen Eye Drop
Levocetirizine
Lodrane
Loratadine
Mescolor
Meclizine
Motrin PM
Naldecon
NyQuil
Olopatidine
Optivar Eye Drop
Ornade
Pannaz
Pataday Eye Drop-24Hr
Patanase Nasal Spray*
Patanol Eye Drop
Periactin
Phenergan
Pheniramine
Promethazine
Pyribenzamine (PBZ)
Ru-Tuss
Rynatan
Semprex D
Tavist
Tanafed DP
Tanafed DMX
Triaminic
Tussionex
Tylenol Cold/Allergy
Tylenol PM
Vistaril*
Xyzal
Zaditor Eye Drop
Zyrtec*

***Astelin, Astepro, Atarax, Azelastine, Cetirizine, Dymista, Hydroxyzine, Patanase Nasal Spray, Vistaril, and Zyrtec:**
DO NOT TAKE FOR SEVEN DAYS PRIOR TO YOUR APPOINTMENT.

Certain Antidepressants and Anti-Anxiety Medications may interfere with skin testing results and should only be discontinued for 5-7 days prior to testing **if instructed by the prescribing doctor:**

Amitriptyline (Elavil)	Imipramine (Tofranil)	Trazadone
Amoxapine	Maprotinine	Trimipramine (Surmontil)
Clomipramine	Nortriptyline	Seroquel
Desipramine	Norpramin	Sinequan
Doxepin	Protriptyline (Vivactil)	

Medications that do **<u>not</u>** interfere with skin testing and **<u>may be continued:</u>**

All Asthma inhalers
Ambien
Antibiotics
Anticonvulsants
Arthritis medications
Cardiac medications
Cholesterol medications
Diabetes medications
Dextromethorphan cough medications (e.g. Delsym)
Glaucoma Eye Drops
Guiafenesin (Mucinex)
High blood pressure medications
Lotemax Eye Drops
Lunesta
Medrol, Methylprednisolone, Prednisolone, Prednisone
Montelukast (Singulair)
Phenylephrine, Pseudoephedrine decongestants
Steroid Nasal Sprays (Fluticasone, Flonase, Nasacort AQ, Nasonex, Omnaris, Qnasl Rhinocort, Triamcinalone, Veramyst, Zetonna)
Stomach acid reducers (Aciphex, Nexium, Prevacid, Prilosec, Protonix, Omeprazole)
Thyroid medications

Antianxiety and Antidepressants that **<u>do not</u>** interfere and **<u>do not</u>** need to be stopped:

Ativan	Escitalopram	Sertraline
Bupropion	Fluoxetine	Valium
Celexa	Lexapro	Wellbutrin
Citalopram	Paxil	Xanax
Effexor	Prozac	Zoloft

<u>If you have any questions about the possible effects of any medication that you are presently taking that is not listed, please do not hesitate to call our office before your visit.</u>

Revised 3/2019

Charleston Allergy & Asthma

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Meredith L. Moore, MD ● Carolyn R. Word, MD ● Lindsey Stoltz Steadman, MD

Will Insurance Cover My Visit?

While the allergy office visit and testing are covered benefits under most insurance plans, the amount of patient responsibility will vary considerably between different insurance companies and plans. There are many insurance companies and even the major carriers have many different policies that employers can choose from for their employees.

Insurance companies are not required to disclose the amounts that are covered and the amounts that the patient will be responsible for to the provider of service. Therefore it is difficult for us, as the provider, to determine what portion of the bill will be the patient's responsibility.

There are many types of allergy testing. A person can be tested to any of the following: inhalants, foods, pharmaceutical drugs, stinging insects, metals, chemicals, or other specific agents. You are billed for the number of substances you are tested to and by the method of testing. (Percutaneous Testing & Intracutaneous Testing)

Prior to your initial visit, you may want to contact your insurance company and ask the following questions:

1. **Do I have allergy and immunotherapy benefits? If so, what are they?**
2. **Do I have any riders on my policy for allergies or asthma?**
3. **If I were to be tested would it be covered?**
4. **Will any of my services need prior authorization?**
5. **What will be my patient liability?**
6. **Do I have a copay on the consultation?**
7. **Do I have to meet a deductible on any office procedures?**

We hope this helps clarify some of the questions you may have concerning coverage of allergy testing. Please remember to document who you speak with when you call your insurance company and the date of the conversation.

If you have any questions or concerns, please feel free to contact our billing office at
(843) 972-2048.

180 Wingo Way #102
Mt. Pleasant, SC 29464
843-881-2030
Fax 843-881-6249

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www.charlestonallergy.com

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Patient Name:	Date of Birth:	Age:
Date of Appointment:	Primary Physician:	

1. INSTRUCTIONS

Please answer the questions as they relate to the person being evaluated. A complete record is important in learning about your allergy problem. Bring this completed form for your first appointment.

Briefly describe the reason for your visit and what you hope to accomplish:____

____

2. PROBLEMS

Have you ever had the following conditions?

Yes	No	(check all items)	Age at onset	Medications tried / Additional comments
		Asthma (Wheezing)		
		Any other Breath Problems		
		Sinus Trouble		
		Hay Fever (Runny, stuffy, itchy nose, sneezing)		
		Hives or Swelling		
		Eczema or Other Rashes		
		Frequent Infections		
		Insect Reactions		

3. FOOD REACTIONS

Have you ever had the following conditions?

Food	Approximate Date	Symptoms	Can food be eaten?		Date food was last eaten
			Yes	No	

4. DRUG REACTIONS

Describe nature of reaction.

Drug	Approximate Date	Symptoms (Respiratory difficulties, hives, swelling, rash, itch, etc.?)

5. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests? ☐ Yes ☐ No   If yes, date__________Physician's Name____________________

Results of these tests: (If possible, please provide us with a copy)______________________________

Have you ever received allergy injections? ☐ Yes ☐ No   If yes, what type?________________________

6. MEDICATIONS

Please list prescription and alternative medications along with dose.

______________________________   ______________________________

______________________________   ______________________________

______________________________   ______________________________

______________________________   ______________________________

7. RESIDENCE

List your past residences with your most recent first. Only city and state required.

City & State	Effects on Symptoms
1.________________________	☐ Better ☐ Worse ☐ No change
2.________________________	☐ Better ☐ Worse ☐ No change

8. HOSPITALIZATIONS/SURGERIES

______________________________   ______________________________

______________________________   ______________________________

PATIENT NAME: ________________________________ ____DATE OF BIRTH:_________________TODAY'S DATE:___________

9. OTHER MEDICAL PROBLEMS — Have you ever had any of the following? Answer all items.

Check all items	Yes	No		Yes	No		Yes	No
Sinus infections	☐	☐	Sarcoidosis	☐	☐	Chronic skin disease	☐	☐
Sinus x-ray/CT Scan	☐	☐	Tuberculosis	☐	☐	Chronic bone/joint disease	☐	☐
Date_____________			Diabetes	☐	☐	Kidney or bladder trouble	☐	☐
Operation on Sinuses	☐	☐	Thyroid Disease	☐	☐	Migraines	☐	☐
Nasal Polyps	☐	☐	Osteoporosis	☐	☐	Seizures	☐	☐
Ear infections	☐	☐	Liver disease (hepatitis)	☐	☐	Attention deficit disorder	☐	☐
Number past year____			Other Chronic Bowel Disease	☐	☐	Depression	☐	☐
Tonsils/adenoids removed	☐	☐	Anemia	☐	☐	Other psychiatric illness	☐	☐
Date___________			Clotting Problems	☐	☐	Pregnant (if current, ___wks)	☐	☐
Pneumonia	☐	☐	HIV infection	☐	☐	Menopause	☐	☐
Number past year____			Immune problems	☐	☐	Birth Control Pills	☐	☐
Chest x-ray/CT Scan	☐	☐	Frequent fungal infections	☐	☐	Other malignancy	☐	☐
Date_____________			Enlarged lymph nodes	☐	☐	Other:	☐	☐

10. RECENT SYMPTOMS — Have you experienced any of these symptoms in the past few weeks? Answer all items.

Check all items	Yes	No		Yes	No		Yes	No
Fever	☐	☐	Sinus pain/pressure	☐	☐	Muscle aches	☐	☐
Fatigue	☐	☐	Decreased sense of smell	☐	☐	Joint pain	☐	☐
Weight loss	☐	☐	Shortness of breath	☐	☐	Joint swelling	☐	☐
Headache	☐	☐	Wheezing	☐	☐	Easy bruising	☐	☐
Dizziness	☐	☐	Cough	☐	☐	Swollen glands	☐	☐
Hearing problems	☐	☐	Coughing up blood	☐	☐	Generalized itching	☐	☐
Vision changes	☐	☐	Chest pain	☐	☐	Hives	☐	☐
Itchy eyes	☐	☐	Heartburn	☐	☐	Other rash	☐	☐
Eye discharge	☐	☐	Nausea	☐	☐	Painful urination	☐	☐
Nasal congestion	☐	☐	Vomiting	☐	☐	Difficulty sleeping	☐	☐
Sneezing	☐	☐	Diarrhea	☐	☐	Depressed mood	☐	☐
Snoring	☐	☐	Blood in stool	☐	☐	Other:	☐	☐

11. FAMILY HISTORY — Do any of your family members have a history of:

	Yes	No	(parents, brothers, sisters, children, aunts, uncles, grandparents, etc.)
Asthma/Bronchitis	☐	☐	
Hay Fever	☐	☐	
Sinusitis	☐	☐	
Eczema	☐	☐	
Hives/Swelling	☐	☐	
Frequent Infections	☐	☐	
Headaches	☐	☐	
Food/Drug Reactions	☐	☐	
Other Respiratory (Cystic Fibrosis, TB, Emphysema)	☐	☐	
Insect Reactions	☐	☐	
Other Allergies	☐	☐	
Is there a family history of any other illnesses?	☐	☐	

12. ENVIRONMENTAL SURVEY

Do you have pets? Yes ☐ No ☐	Do your pets spend time indoors? Yes ☐ No ☐	What kind and how many?
If adult, what type of work do you do?		
Are you exposed to anything at work which may aggravate your condition? Which things?		
If small child, day care center?		

13. MARITAL STATUS

Married ☐ Single ☐ Widowed ☐ Separated ☐ Number of Children ___________

14. SMOKING

Have you ever smoked or lived with someone who smoked? Yes ☐ No ☐ If yes, how many years? _________ When did you stop? _______

Do you presently smoke or live with someone who smokes? Yes ☐ No ☐ Average cigarettes per day? _________

If you still smoke, do you think you could stop? Yes ☐ No ☐ Which other family members smoke? ________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________ ______________________

Signature of Patient, Parent or Guardian Date

BRING THIS COMPLETED FORM WITH YOU FOR YOUR FIRST APPOINTMENT. THANK YOU.

Charleston Allergy & Asthma

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Meredith L. Moore, MD ● Carolyn R. Word, MD ● Lindsey Stoltz Steadman, MD

NOTICE OF PRIVACY PRACTICES

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

Federal Regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) requires that the practice provide you with this notice.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, workers compensation carrier or from credit card companies that you may use to pay for services, or consumer reporting agencies relating to collection of premiums or reimbursement. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. However, should you need to restrict disclosure of your protected health information on a particular date of service, you will be required to pay out of pocket for the services. Any information regarding those services will be restricted and not released to anyone other than the patient.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Charleston Allergy & Asthma. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Coroners, Medical Examiners, Funeral Directors, Organ Donation. Your health information may be disclosed to coroners and/or medical examiners for purposes of identification, determining cause of death, or other duties as required by law. Funeral Directors may need your health information in the performance of carrying out their duties. Your health information may also be used and disclosed for the purpose of cadaveric organ, eye or tissue donation.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fund Raising. Under HIPAA guidelines, your health information may be used in fund-raising efforts unless you specifically request the information withheld. Charleston Allergy & Asthma will not use your information for any type of fund-raising endeavor.

Research. Your protected health information will not be disclosed for research, unless written authorization is obtained.

Prohibited Uses and Disclosures for Protected Health Information

- Genetic information for underwriting, determination of eligibility and benefits, computation of premium or contribution amounts, application of any pre-existing condition, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. Written authorization is necessary.
- The sale of protected health information by the health care provider or its business associates for a fee. A cost-based fee for preparation and transmittal purposes to an authorized provider or insurance company is permissible.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restriction on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to appoint someone your medical power of attorney or legal guardian, that person can exercise your rights and make choices about your health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Charleston Allergy & Asthma Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our privacy practices.
We are required to notify you of a breach, no later than 60 days after the discovery, which results in the compromise of security or privacy of your protected health information.
We are required to abide to the privacy policies and practices that are outlined in this notice.
We are required to abide to the US Department of Health and Human Services, Office for Civil Rights, HIPAA Regulation Text, 45 CFR Parts 160, 162, and 164.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. Due to time allotments, you will be contacted to schedule an appointment with our medical staff for this purpose.

Concerns

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Charleston Allergy & Asthma
Attn: Penny Linder, Privacy Officer for HIPAA
180 Wingo Way, Ste 102
Mt. Pleasant, SC 29464

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

For further information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Effective September 2013

Revised April 2018

LABWORK REQUESTED

The physician may require that x-rays and/or laboratory procedures be performed in order to obtain a diagnosis.

Some facilities do not accept or participate with all insurance plans. It is your responsibility to determine which lab participates with your insurance plan.

Due to ASTHMATIC REACTIONS among our patients, we ask that you

please not wear COLOGNE OR PERFUME

at the time of your visit.

Due to FOOD ALLERGIES among our patients, we ask you to please not bring

FOOD OR DRINKS in our office.

We thank you and appreciate your cooperation,

Charleston Allergy & Asthma

Charleston Allergy & Asthma

HIPAA ACKNOWLEDGEMENT

I, ____ (patient), acknowledge that I have received a copy of **Charleston Allergy and Asthma's** Notice Regarding Privacy of Personal Health Information.

__________________________ ____

Date Patient's Name (PRINT)

____

Patient or Parent Signature

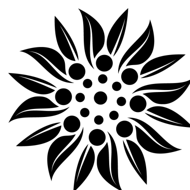
____

Social Security Number (for verification purposes)

Below is a list of persons who are authorized to view any medical information in this medical chart:

___________________________________ ___________________________________

___________________________________ ___________________________________



CHARLESTON
ALLERGY & ASTHMA
RESEARCH

We have a clinical research team that may review this chart for potential studies. Charleston Allergy & Asthma Research has participated in over 300 studies and with each study you receive compensation for time and travel and free medications. Please indicate below if Charleston Allergy & Asthma Research may review your chart*:

____yes ____no

*checking "yes" does not mean that you will be contacted, as not all patients qualify for studies.

TELEHEALTH PATIENT CONSENT/REFUSAL FORM

Patient Name: ______________________________ Date of Birth: _________________

Cell Phone: ________________________ Email: ________________________________

1. PURPOSE: The purpose of this form is to obtain your consent to participate in telehealth consultation for outpatient evaluation and management of acute and chronic health conditions. Telehealth allows you to communicate with your physician about your health and medical conditions to determine a treatment plan.
   a. Electronic systems will incorporate 128-bit HIPAA network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure against corruption. During a "national emergency" authorization may be granted to use a less secure platform. You will be notified if this occurs.
   b. The patient and/or guardian will not hold the physician liable for any clinical information that is lost due to technical failures.
2. BENEFITS: Improved access to medical care by allowing patients to receive medical care from outside a healthcare facility.
3. RISKS: As with any medical care there are potential risks associated with the use of telemedicine: information transmitted may not be sufficient to allow for appropriate decision making, delays could occur due to deficiencies or failure of the equipment, in rare cases security protocols could fail causing loss of privacy of personal medical information. Your provider may advise that an in-person visit is necessary.
4. NATURE OF TELEHEALTH CONSULT/VISIT: During the telehealth consultation:
   a. The visit will take place through interactive real-time audio and video communication. You will have the opportunity to ask questions and discuss your health concerns with your provider.
   b. Details of your current health concerns and medical history will be discussed.
   c. A physical examination of you may take place.
   d. Photos may be taken during the visit and will be loaded directly into the medical record. This will only be done with your verbal consent (picture of a rash, which can be used to consult with other providers).
5. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to telehealth visits. Sharing of any patient-identifiable images or information for this telehealth visit to researchers or other entities shall not occur without your consent.
6. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and South Carolina state law apply to information disclosed during telehealth visits.
7. RIGHTS: You may withhold or withdraw consent to telehealth care at any time without affecting your right to future care or treatment.
8. PRESCRIBING: The physician will prescribe medications that are appropriate for the symptoms and on diagnosis made during the telehealth visits. Prescriptions will be sent electronically through the electronic medical record to the patient's pharmacy. Prescription of controlled substances from schedule II through IV will not be prescribed through telehealth visits.
9. EMERGENCY EVENT: If a medical emergency occurs during the telehealth visit, your physician will take necessary steps to secure appropriate and timely care for the patient. If the patient is incapacitated, the physician will call 911 emergency services and remain on the line until care has been transferred. If a family member is available, the physician will guide them through contacting 911 emergency services. The patient and/or guardian agrees that the telehealth physician, nor Charleston Allergy & Asthma, will be held liable for any cost incurred for emergency services care that was activated on the best judgement of the physician with the available information.

10. AFTER HOURS CARE: Patients who have an established care relationship with a Charleston Allergy & Asthma physician may access non-emergent care after normal business hours by contacting the main office number.
11. RISKS, CONSEQUENCES & BENEFITS: You have been advised of the potential risks, consequences and benefits of telehealth. Your provider has discussed this and you have had an opportunity to ask questions about this information. All your questions have been answered and you understand the written word above.

I **AGREE or DISAGREE** (CIRCLE ONE) to participate in telehealth visits as discussed above:

Signature: ____

If signed by someone other than the patient, indicate relationship: ___________________________.

DATE: _____________________________ TIME: _______________________________

WITNESS: ____

COUNSELING PHYSICIAN: ____