



Tottori Allergy & Asthma Associates

New Patient Pediatric 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)

David H. Tottori, M.D.
Thomas Chu, PA-C
Rebecca Kim, PA-C
Morgan Bush, PA-C
Raven Uy, 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. ☐ Estab. Pt.
Nuevo Estaidencido

PATIENT NUMBER

PATIENT INFORMATION

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 Nacimiento)	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 Telefono de Trabajo
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 Nacimiento)	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 Nacimiento)	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 & Asthma 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 (CHILDREN)

David H. Tottori, M.D.
Thomas Chu, PA-C
Rebecca Kim, PA-C
Morgan Bush, PA-C
Raven Uy, PA-C

Confidential Record: Information will not be released unless authorized by you.

4000 East Charleston Blvd., Suite 100
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9020 West Cheyenne Avenue
Las Vegas, NV 89129 • (702) 240-4233

Name _____ Age _____ Birthdate _____

Parent's Name _____

Address _____

Telephone (home) _____ (work) _____

Pediatrician _____ Referred by _____

Please describe your child's problem: _____

Symptoms: (Please check all current symptoms)

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Itching of the eyes | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Sinus infection | <input type="checkbox"/> Watery eyes |
| <input type="checkbox"/> Itching of the ears | <input type="checkbox"/> Swelling of the eyelids | <input type="checkbox"/> Nausea | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Itching of the throat |
| <input type="checkbox"/> Swelling of the lips | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Frequent clearing of the throat | |
| <input type="checkbox"/> Swelling of the body | <input type="checkbox"/> Stomach cramps | <input type="checkbox"/> Blocked nose | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Itching of the nose | <input type="checkbox"/> Coughing | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Ear fullness | <input type="checkbox"/> Other _____ | | |

Please answer these questions as they apply to the symptoms which you have checked:

When did these symptoms first occur? _____

How often and when do the symptoms occur? _____

Is there any seasonal variation in your symptoms, and if so, when are they worse? _____

Is there anything that you have identified which can cause symptoms or make them worse? (Example: exercise, wind, cold air, smoke, aspirin, cleaning chemicals, barns/hay, lawn mowing/grass, anxiety, mold, pets, food, dust, heat, weather changes, perfumes, upper respiratory infections). _____

What medications has your child had to help control the allergic symptoms? Please list all tabs, capsules, liquids, lotions, creams, ointments, nasal sprays and bronchial inhalers here. _____

Has your child ever received steroids/Prednisone? ☐ No ☐ Yes _____

Medical History: Have you ever had:

- | | | | |
|------------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Croup |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Sinus infections |

Has your child ever been hospitalized? ☐ No ☐ Yes (if so, when and details) _____

Has your child undergone surgery? ☐ No ☐ Yes (if so, when and details) _____

Are your child's immunizations up-to-date? ☐ Yes ☐ No

Has your child ever had allergy tests? ☐ No ☐ Yes (if yes, when, where and results) Example: skin or blood (RAST) test

Has your child ever had allergy shots? ☐ No ☐ Yes (when, how long, adverse reactions) _____

Birth History:

Birth weight_____ Type of Delivery (C-section, spontaneous/induced)

Complications ☐ No ☐ Yes _____

Growth/Development:age when crawled_____ walked _____

Compared to siblings were milestones delayed? ☐ No ☐ Yes**Food History:**Are you aware of any foods that may cause your child symptoms? ☐ No ☐ Yes (if yes, list food type and reaction)_____**Drug History:**Has your child ever had any reactions to any drug?☐ No ☐ Yes (if yes, list drug and type of reaction)_____**Family History:**

Do any of these members of your family have allergies and/or asthma?

☐ Mother ☐ Grandparents ☐ Brother(s) ☐ Father ☐ Aunt(s) or Uncle(s) ☐ Sister(s)

List any diseases that tend to run in your family: _____

Home Environment:

How long has your child lived at your current residence? State where born?_____

Type of residence: ☐ House ☐ Apartment ☐ Mobile home ☐ Other_____

Does your house have:

☐ Central air conditioning ☐ Area rugs ☐ Electric heat ☐ Window A/C units ☐ Electrostatic air filter☐ Evaporative cooler ☐ Attic fan ☐ Gas Heat ☐ Humidifier

Does your child's bedroom have:

☐ Carpeting ☐ Ceiling fan ☐ Potted plants ☐ Mattress/box springs ☐ Venetian (mini) blinds☐ Stuffed animals ☐ Waterbed ☐ Plastic mattress cover ☐ Other_____Type of pillow: ☐ Feather ☐ Foam ☐ Fiberfill (Hollofill) ☐ Other_____**Pets:**Do you have a: ☐ Cat ☐ Bird ☐ Dog ☐ Other animal (if yes, what?)_____

How long have you had your pet?_____

Does being around your pet aggravate your allergic symptoms? ☐ No ☐ Yes

Are the pets inside the house, outside, or both?_____

Does any household member smoke? ☐ No ☐ Yes**Father's** Occupation:_____ **Mother's** Occupation:_____**School/Occupation:**

How many days of school have been missed due to illness?

If child is a toddler, are they in daycare? ☐ No ☐ Yes (if so, how many children attend?)_____**Review of Systems:****Does your child have or had the following: (please circle)**

Skin reaction to poison ivy/oak, chemicals, jewelry/snaps or buckles.

Generalized reaction to an insect sting or bite.

Hives, swelling, or eczema.

Headache (if so, where, how often, how long)._____

Problem with hearing. Hearing test last performed? _____

Recurrent nose bleeds.

Collapse of part of the lung.

Chest X-Ray: (if so, when and results)._____

Colic in infancy, vomiting, abdominal pain/swelling, constipation.

Blood or mucous in stool.

Pain with urination.

Unexplained fever, weight loss or weight gain.

Joint pain or swelling, or limping.

Heart murmur, "blue" or cyanotic spells, fast heartbeat.

Seizures, convulsions, fits.

Hyperactivity.

Frequent infections (please describe)._____

Is there anything else that might be important for the doctor to know? _____



HIPAA Notice of Privacy Practices

4000 East Charleston Blvd., Suite 100
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David H. Tottori, M.D.
Thomas Chu, PA-C
Rebecca Kim, PA-C
Morgan Bush, PA-C
Raven Uy, PA-C

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 operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, including the need for your authorization to use or disclose PHI for reasons not covered within this Notice, which you may limit or terminate as permitted by law. PHI includes information about you, including personal and demographic information that may identify you—your date of birth, address, social security number, and image and likeness, and more—and that relates to your past, present, and future physical or mental health condition and related health care services. We are required by law to: (i) maintain the privacy of your PHI; (ii) give you this notice of our legal duties and privacy practices regarding health information about you, including your PHI; and (iii) follow the then-effective terms of this notice, which may be changed from time to time as set forth herein.

We reserve the right to change the terms of this notice and to make the new provisions effective for all PHI 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 PHI

The following describes the ways we may use and disclose your PHI.

Treatment: We will use and disclose your PHI 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 PHI 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 PHI 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 PHI 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 PHI.

Appointment Reminders: We may use and disclose your PHI 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 PHI 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 PHI 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 PHI. We may also share your PHI 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 PHI with a person who is involved in your 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.

Privacy: We reserve the right to contact you to schedule or confirm an appointment by either E-Mail, text, mobile, or home number. You may revoke the right to be contacted by any means and choose to opt out of being contacted by a specific means by submitting a request to our office in writing at any time. You grant permission for Tottori Allergy & Asthma Associates to leave the following information via voice mail, E-Mail or text: appointment notice, patient first and last name, appointment date/time and location.

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 PHI: Other than the transition provisions in 45 C.F.R. 164.532, we will obtain your authorization for any disclosure of your PHI 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 PHI 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 PHI.

You have the right to inspect, access and request a copy of your PHI: You have the right to inspect, access and request a copy of your PHI, 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 PHI that is now subject to law that prohibits access to PHI. You may elect to receive your PHI in which ever requested form you choose. For example, you may receive your PHI by an electronic format, by mail, by email or request a hard copy. If you elect to receive your PHI electronically, we will provide your PHI in a readily producible format per your request. Please note, if you wish to have your PHI 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 PHI 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 PHI: This means you may ask us not to use or disclose any part of your PHI 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 PHI, your PHI 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 PHI, as required by law. You have the right to restrict certain health plan disclosures: You have the right to restrict certain disclosure of your PHI 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 PHI: 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 PHI: 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 **August 1, 2019.**

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

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:

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

Use and Disclosure Authorization Form

I, _____, give permission to Tottori Allergy & Asthma Associates, PC to:

☐ Use the following protected health information, and/or

☐ Disclose the following protected health information to:

Information to be disclosed (check all that apply):

☐ Medical Records

☐ Treatment Records

☐ Diagnostic Records

☐ Psychotherapy Notes

☐ Other:

This protected health information is being used or disclosed for the following purposes (check all that apply):

☐ Treatment

☐ Diagnosis

☐ Marketing

☐ Sale (amount must be disclosed) \$ _____

This authorization expires on or when

Specify date or event that relates to the purpose of this use or disclosure.

Note: If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed. Finally, you may revoke this authorization in writing at any time by sending written notification to Manuel Testa at 4000 E Charleston Blvd Ste 100, Las Vegas, NV 89104. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Signature of Participant or Personal Representative

Date

Printed Name of Participant or Personal Representative

Description of Personal Representative's Authority

**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:**

_____. **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.**

I have read the above foregoing Authorization for Release of Information and do hereby 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