

PATIENT REGISTRATION

VERY IMPORTANT:

DO NOT TAKE ANY ANTIHISTAMINES SEVEN (7) DAYS PRIOR TO YOUR APPOINTMENT

PATIENT INFORMATION

***Bring this form to your appointment .**

Date:	D.O.B.:	Age:	Patient S.S.#:
PATIENT NAME			
Last:	First:	Middle Initial:	
Sex: Male Female	Marital Status:	Single	Married Other
Address:	E-mail address:		
	Cell #:		
Home Phone:	Work Phone:		
Employer:	Occupation:		
Primary Care Physician:	Referred by:		
Have you or a family member been treated in this office before ? Yes No Name:			

RESPONSIBLE PARTY

(GUARANTOR/ INSURANCE POLICY HOLDER)

POLICY HOLDER INFORMATION			
Last:	First:	Middle Initial:	
D.O.B.:	Soc. Sec.#:		
Relationship to Patient:	Marital Status:	Single	Married Other
Address:	E-mail address:		
	Cell #:		
Home Phone:	Work Phone:		
Employer:	Address:		

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Relationship to Patient:
Home Phone:	Work Phone:

INSURANCE INFORMATION

(or provide a copy of your insurance card)

Primary Insurance:	Secondary Insurance:
Name of Insured:	Name of Insured:
Relationship to Patient:	Relationship to Patient:
Insured's Birthdate:	Insured's Birthdate:
Insured's S.S. #:	Insured's S.S. #:
Employer:	Employer:
ID#:	ID#:
Group#:	Group#:
Ins. Co. Address:	Ins. Co. Address:
Effective Dates From: To:	Effective Dates From: To:
Does your Managed Care or insurance plan require a referral? Yes No	

AUTHORIZED, RELEASE, & CONSENT

<p>Authorization to release information: I authorize the physician to release any information acquired in the course of my or my child's treatment to third party payors and/or other health care practitioners.</p> <p>Authorization to pay benefits to physician: I authorize payment directly to the physician surgical or medical benefits, if any, otherwise payable to me for his/her services as described, and agree to pay for non-covered services.</p> <p>Responsibility for payment of rejected services: I understand that my managed care company may require prior authorized or a primary care for referral for treatment in this office. If I do not obtain the required authorization or referral, I agree to be responsible for payment of services rendered on my or my dependent's behalf.</p> <p>Authorization to treat a minor (under age 18): In the event of an emergency, and I cannot be contacted, I give permission to the doctors, or the persons under their instruction, to treat my child in their office or hospital as required by the events of that emergency situation.</p>	
X _____ Signature of patient or parent if a minor	_____ Date:

FAIRFIELD COUNTY ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES
148 East Avenue, Ste. 3G 80 Mill River Street, Ste. 2100 2 ½ Dearfield Drive
Norwalk, CT 06851 Stamford, CT 06902 Greenwich, CT 06831

SIGNATURE ON FILE FORM
AUTHORIZATION OF ACCESS TO MEDICAL RECORDS
AUTHORIZATION TO CONTACT PATIENT REGARDING APPOINTMENTS
AUTHORIZATION TO CONTACT PATIENT REGARDING TEST RESULTS

In accordance with the new Federal and State government regulations under HIPAA
Please initial each item.

1. I _____ provide this signature **as authorization for payment** of all my medical services to
Fairfield County Allergy, Asthma and Immunology Associates, PC (Robert Biondi, M.D., Mitchell Lester,
M.D., Mark Litchman, M.D., Agnes Matczuk, M.D., Joseph Sproviero, M.D.) to be received at the
following address:

Fairfield County Allergy, Asthma & Immunology Associates, P.C.
148 East Avenue – Suite 3G
Norwalk, CT 06851

I understand that non-covered services and services rejected by my insurance carrier will become solely my
(patient or guardian) responsibility.

2. I _____ authorize FCAAIA **to permit the release of medical records** to other health care providers, or
other information necessary to process claims. I also request payment of government benefits directly to
FCAAIA for any/or all of the physicians, at the above address for all medical services rendered.

3. I _____ authorize the physicians, as well as the office staff, **to contact me to confirm appointments.**
They May _____ May NOT _____ leave a message on an answering machine or with persons taking messages
at the phone numbers I provide.

4. I _____ authorize the physician, as well as the office staff, **to contact me regarding results** of medical
tests or procedures. They May _____ or May NOT _____ leave a message on an answering machine or
with persons taking messages at the phone numbers I provide on my registration form.

5. I _____ authorize the physicians, as well as the office staff, **to phone my selected pharmacy** with
prescriptions.

6. I _____ authorize the physician, in the event of an **emergency** and I cannot be contacted, **to treat my**
minor child (under 18) in the office or hospital as required.

7. I _____ May _____ May NOT _____ receive **acknowledgement via e-mail** of requests I make on-line for
prescriptions and billing information.

8. I have read and understand the billing policies and guarantor payment agreement on the back of this
form.

Signature of Patient or Legal Representative

Date _____

THIS FORM IS VALID UNTIL INDICATED BY THE ABOVE SIGNEE IN WRITING OF
OTHER ARRANGEMENTS. over . . .

**FAIRFIELD COUNTY ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES
BILLING POLICIES AND GUARANTOR PAYMENT AGREEMENT**

MANAGED CARE & MEDICARE

If you have a managed care plan in which we participate or Medicare, we will bill your insurance company/Medicare directly for our services. Please provide us with **CURRENT** and **ACCURATE** insurance information. If you require referrals from your primary care provider, it is your responsibility to secure these. Please present your insurance card at the time of each office and the time of each allergy shot visit and notify us immediately of any insurance changes.

Co-pays must be paid at time of service. Failure to do so may result in an additional \$10 charge.

UNCOVERED SERVICES

If services provided are not covered by your insurance plan, then you are responsible. There is a one-time annual fee each calendar year of \$25 per patient for non-covered medical services, e.g., completion of school, camp and/or travel forms. You are also responsible for fees incurred if we do not have your current insurance information **AT THE TIME OF SERVICE**. Any charges which are more than 30 days past due and are the patient's responsibility are subject to an interest charge of 18% per annum.

PRIVATE INSURANCE

If you have private insurance, professional services rendered are charged to you the patient. As a courtesy, we will submit your claim to your insurance company, however any outstanding balance is your responsibility. Accounts that are more than 90 days overdue are subject to a rebilling fee. Any charges which are more than 30 days past due and are the patient's responsibility are subject to an interest charge of 18% per annum. We accept cash, check or credit cards.

Even though you have a filed insurance claim, you will receive a monthly statement if you have a balance due. Our office will not negotiate settlements on disputed claims. If your claim is denied, you will be informed and you should communicate directly with your insurance company. Payment for services is the patient's responsibility even if the insurance company wrongfully denies the claims.

COLLECTION POLICY

If we must refer your account to a collection agency or to a law firm to collect an unpaid balance, you will have to pay the costs of collection as well as any unpaid balance in order to remain a patient of our practice. You are responsible for bank charges associated with checks not honored by our bank.

If your account is placed in collection, and/or if you do not pay an outstanding balance within a reasonable period of time, you will be discharged from our practice. We will send you a medical records release for your signature so that we can send a copy of your records to your new physician.

MISSED VISITS

If you provide us with 24-hours advance notice to cancel an appointment, we will gladly reschedule your appointment. If you fail to give advance notice, we reserve the right to bill you for the missed visit.

We thank you in advance for your cooperation with our billing policies.

FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.

ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

DIPLOMATES OF THE AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

148 East Avenue, Ste. 3G
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2 ½ Dearfield Drive
Greenwich, CT 06831

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. Please review this notice carefully.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices.

We realize that these laws are complicated, but we must provide you with the following information:

- How we may use and disclose your identifiable health information.
- Your privacy rights in regard to your PHI
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of our records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of your current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

If you have questions about this notice, please contact the office manager.

We may use and disclose your individually identifiable health information (PHI) in the following ways. The following categories describe the different ways in which we may use and disclose your PHI.

- 1. Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. The people who work in our practice, including but not limited to, our doctors and nurses, may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

Privacy Policy Page 2 of 5

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for services and items you may receive from us. We may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member involved with your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter/nanny take their child to the office for treatment. In this example, this person might have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

Use and Disclosure of your PHI in Certain Special Circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of maintaining vital records, Reporting child abuse or neglect, Preventing or controlling disease, injury or disability. Notifying a person regarding potential exposure to a communicable disease
Notifying a person regarding a potential risk for spreading or contracting a disease or condition, Reporting reactions to drugs or problems with products or devices
Notifying individuals if a product or device they may be using has been recalled
Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient, including domestic violence; however we will only disclose

this information if the patient agrees or we are required or authorized by law to disclose. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities may include investigations, audits, surveys, licensure and disciplinary actions, civil, administrative, criminal procedures, actions, or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena or other lawful process or by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official: Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.

Concerning a death we believe has resulted from criminal conduct

Regarding criminal conduct in our offices

In response to a warrant, summons, court order, subpoena or similar legal process

To identify or locate a suspect, material witness, fugitive or missing person

In an emergency, to report a crime (including the location of the victim(s) of the crime, or the description, identify or location of the perpetrator.

Deceased Patients. Our practice may release PHI as requested or required according to office policy.

Serious Threats to Health of Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another person. Under these circumstances, we will only make disclosures to a person or organization able to prevent the threat.

Military Our practice may disclose your PHI if you are a member of the military forces, including veterans, and if requested by the authorities.

National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials conducting formal investigations.

Workers Compensation. Our practice may release your PHI for workers' compensation and similar programs.

YOUR RIGHTS REGARDING YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the PHI that we maintain about you.

Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you only at home, or only at work. In order to request a type of confidential communication you must make a written request specifying the requested method of conduct, or the location where you wish to be contacted. **Our practice staff will accommodate reasonable requests.** You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family and friends. **We are not required to agree to your request.** However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing. Your request must describe in a clear and concise fashion: a) the information you wish restricted; b) whether you are requesting to limit our practice's use disclosure or both; and c) to whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to this practice in order to inspect and/or obtain a copy of your PHI. Our practice charges a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to our practice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request in writing and the reason supporting your request. Also we may deny your request if you ask us to amend information that is in our opinion: accurate and complete; not part of the PHI kept by or for the practice; not part of the PHI which you would be permitted to inspect or copy ;or not created by our practice unless the individual or identity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures”. An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse, or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our practice. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact any member of this practice.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, which must be in writing, contact the office manager at the location you are normally seen. You will NOT be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time IN WRITING. After you revoke our authorization, we will no longer use or disclosure your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OR OUR HEALTH INFORMATION PRIVACY PRACTICES, PLEASE CONTACT OUR ADMINISTRATOR.

FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.

ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

DIPLOMATES OF THE AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

**148 East Avenue, Ste. 3G
Norwalk, CT 06851**

**80 Mill River Street, Ste. 2100
Stamford, CT 06902**

**2 ½ Dearfield Drive
Greenwich, CT 06831**

I ACKNOWLEDGE THAT I HAVE **RECEIVED** A COPY OF THE PRIVACY PRACTICES FOR FAIRFIELD COUNTY ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES. This acknowledgement will be kept on file by them.

PRINT PATIENT NAME

DOB

PARENT / GUARDIAN

SIGNATURE

FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.

ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

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NORWALK OFFICE: **148 East Avenue, Suite 3G, Norwalk, CT 06851**
(203) 838-4034 Phone (203) 853-6361 Fax

From I-95 Northbound - Exit 16

Turn left at end of ramp. Left at 2nd traffic light (Riverview East), proceed down the hill.

From I-95 Southbound - Exit 16

Turn right at end of ramp. Left at 1st traffic light (Riverview East), proceed down the hill.

From Merritt Parkway Northbound - Exit 41

Exit 39A, Route 7 Connector South to I-95 North. Exit 16, turn left at end of ramp. Left at 2nd traffic light (Riverview East), proceed down the hill.

From Merritt Parkway Southbound - Exit 41

Exit 41, turn left off exit ramp. Left at 1st traffic light (Three Bears Restaurant). Follow this road, cross over Post Road (Rte. 1), and go to the fourth light. Right to Riverview East, proceed down the hill.

GREENWICH OFFICE: **2 1/2 Dearfield Drive, Greenwich, CT 06831**
(203) 869-2080 Phone (203) 869-1056 Fax

From I-95 Southbound

Exit 3 (Arch Street), at traffic light take right, 3rd street take left onto SoundView Dr., top of hill bear right onto Field Point Rd., 2nd traffic light bear left continuing on Field Point Rd., Go straight across 4way intersection, we are the second driveway on left.

From I-95 Northbound

Exit 3 (Arch Street), at traffic light take left, 3rd street take left onto SoundView Dr., top of hill bear right onto Field Point Rd., 2nd traffic light bear left continuing on Field Point Rd., Go straight across 4way intersection, we are the second driveway on left.

From Merrit Parkway Southbound

Exit 29 (Lake Avenue), follow Greenwich business district signs, go exactly 1/2 way around the rotary on to Dearfield Drive, 2nd block our driveway is on the right.

From Merrit Parkway Northbound

Exit 28 (Round Hill Road), end of ramp take right towards Greenwich business district, continue straight for several miles, fork in road bear right (Lake Avenue), go exactly 1/2 way round the rotary on to Dearfield Drive, 2nd block our driveway is on the right

STAMFORD OFFICE: 80 Mill River Street, Suite 2100, Stamford, CT 06902
(203) 357-1511 Phone (203) 357-1743 Fax

From I-95 Northbound: Exit 8 - Atlantic Street

At end of ramp left under Thruway. Continue straight on Atlantic past mall and stay left. At intersection of Atlantic & Broad Street turn left. At 3rd light make a left turn onto Mill River Street. Driveway is 1st right.

From I-95 Southbound: Exit 8 - Elm Street

Work your way to right and make a right at Elm. Straight on Elm to 3rd light, left onto Broad to sixth light - left onto Mill River. Driveway is 1st right.

From Merritt Parkway: Exit 35

Right onto Route 137 South (High Ridge Road) to downtown Stamford. Approximately 2.8 miles - 137 South leaves High Ridge Road and follows Washington Boulevard. Right onto Washington Blvd., continue for 1.4 miles to Broad. Right onto Broad. At 1st light turn left onto Mill River. Drive is first right.

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