5720 Ralston St, Suite 205, Ventura, CA 93003
451 W. Gonzales Rd, Suite 150, Oxnard, CA 93036
3801 Las Posas Rd, Suite 211, Camarillo, CA 93010
23928 Lyons Ave, Suite 208, Newhall, CA 91321
Ph: 805-658-9500 Fax: 805-658-9501

A.A.I.M. GROUP
Allergy, Asthma, & Immunology Medical Group
Established in 1978

Prashant Verma, M.D.
Preeti Chopra, M.D.
Sanjiv Verma, M.D.
& Associates
www.AsthmaAllergyDoctors.com

Welcome to Allergy, Asthma, & Immunology Medical Group! We look forward to welcoming you into our practice/family :)

In order to make your visit with one of our providers a smooth process, we ask you to fill out some paperwork prior to scheduling your appointment. We have some FAQs below to answer some questions you may have.

Q: Why do I need to fill out so many pages?
A: We understand that the paperwork seems long and tedious. However, by completing them accurately and filling them out entirely, our providers will be able to give you the best quality care possible.

Q: Why do you need my credit card number?
A: Due to COVID we have had many patients request a contactless form of payment. Your credit card number is placed in a secured area. Even if we have your card on file, we will only charge it with your verbal authorization first. Should you choose not to provide a card on file,that is totally fine :) Please just click the DECLINE box on the form.

Q: Why is there a no show policy? Do you enforce it?
A: Due to the increasing need for appointments for our patients and many patients simply not showing up we have had to institute a strict no show policy as we have staffing based on our scheduling needs. We feel it is important to hold individuals accountable for their appointments just as other facets of life do. We apologize if it seems a bit firm.

Q: Can I fill out the paperwork any other way?
A: Absolutely! You can ask one of our receptionists for assistance, and they will happily help you.

Q: What happens next?
A: Once you complete all of your paperwork we will reach out to you to schedule your appointment with one of our providers.

If you have any other questions, please reach out to us. Our providers look forward to meeting with you and helping with your allergy, asthma, or immunology needs!

Sincerely,
AAIM Group

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REGISTRATION FORM

DEMOGRAPHIC INFORMATION

Patient Name_____ Nick Name_____ Today's Date_____

Date of Birth _____ Sex _____ Social Security #_____

Home Address_____ City/State/ZIP_____

Cell #_____ Home #_____ Work #_____

E-mail Address: _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ Effective Date_____

Policy Number_____ Insurance Group Number_____

POLICY HOLDER INFORMATION:

Name:_____ *Relationship to Patient:_____

Phone #:_____Date of Birth_____ Social Security #_____

Address:_____

SECONDARY INSURANCE_____ Effective Date_____

Policy Number_____ Insurance Group Number_____

OTHER INFORMATION

PRIMARY CARE PROVIDER: _____Phone_____Fax_____

Emergency Contact: _____ Relationship_____ Phone_____

FEDERAL GOVERNMENT REQUIRED QUESTIONS

Patient Race: ▫ Afr American ▫Asian ▫Caucasian ▫ Hispanic ▫ Pac. Islander ▫ Native American ▫Other_____

PREFERRED LANGUAGE: ▫ English ▫ Spanish ▫ Other _____

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Please initial in all boxes below and sign at the bottom of the page to acknowledge you have read and understood our policies.

PAYMENT POLICIES

	$5 FEE FOR COPAYS NOT PAID AT TIME OF SERVICE
	$50 NO SHOW FEE FOR ANY MISSED APPOINTMENT not canceled or rescheduled 24 hours prior to the appointment. (Please be aware **MINORS** must be present for the appointment regardless of the age or this will result in a NO SHOW.)
	$35 NON SUFFICIENT FUNDS CHARGE FOR ANY RETURNED CHECK FROM THE BANK.
	Assignment of benefits are payable to the doctors.
	If you are a patient without insurance, all charges are due at the time of visit.
	I understand that any payment I make to Allergy, Asthma, & Immunology Medical Group by credit card will result in my credit card information being saved (tokenized) with Transafe. This will then be referred to as my card on file.
	I hereby authorize Allergy, Asthma, & Immunology Medical Group to charge my credit card on file for any portion determined to be patient responsibility once a claim has been processed by insurance.
	I understand that if my outstanding balance has not been paid in full 60 days after the date of my first statement my account is subject to a $10 late fee and/or 2% interest. I understand that every subsequent 30 days another $10 late fee and/or 2% interest will be applied.

Patient Name: _____ **DOB:** _____

_____ _____ _____

Patient/Responsible Party (Printed) **Signature** **Date**

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PATIENT AGREEMENTS

	I will confirm my appointment and understand that failure to do so may result in cancellation.
	As an injection patient, I understand that I must be seen at a minimum every 6 months. If I cancel or reschedule, I understand my treatment will be continued as a 30-day courtesy until my office visit has been completed. (**Only initial if applicable**).
	I understand if I want or need an individual other than myself contacting the office I will need a Medical Proxy Consent on file before any changes or information can be discussed.
	I will treat staff with respect and dignity whether in the clinic, on the phone, or by video.
	I understand the Provider will make every effort to be available to but may not always be able to see me on a same-day basis thus I should use Emergency Room or Urgent care for same-day services. In the event of a medical emergency, I agree to call 911 first.
	There is a 48-72 hour turn around for prescription refills. If I have not seen the physician in 6 months or according to the last office visit directive, the prescription will be denied.
	Refills will be made only during regular office hours. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made.
	I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine. I understand doing so is a felony crime.

Patient Name: _____ **DOB:** _____

_____ _____ _____

Patient/Responsible Party (Printed) **Signature** **Date**

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NEW PATIENT QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

Patient Name _____ Age _____ DOB_____

City Patient Resides in _____ Current Occupation _____

Exposure to allergens at work (currently or previously)? _____

Primary Care Physician/Provider _____ Phone:_____

Referring Physician/Provider (if different): _____ Phone: _____

LIST THE REASONS FOR YOUR VISIT TODAY (CHIEF COMPLAINTS):

1. _____ Since When _____
2. _____ Since When _____
3. _____ Since When _____

Other specialists seen for these problems: _____

PHARMACY INFORMATION:

Local Retail Pharmacy Name _____ Cross Streets _____ Phone _____

List All Present Medications/Supplements/Herbs that you use DAILY or AS NEEDED:

DRUG	DOSE	ANY RELIEF	ANY SIDE EFFECTS	TAKING SINCE

I have Nose, Sinus, Throat symptoms: ▢ NO (go to next) ▢ YES: Describe:_____

I have Eyes, Ear, Throat symptoms: ▢ NO (go to next) ▢ YES: Describe:_____

I have a diagnosis of Asthma: ▢ NO (go to next) ▢ YES: Since when? _____ Triggers? _____
Meds Tried? _____
Days missed of school/work in 1 yr _____
Visits to ER or Urgent Care in 1 yr _____
Oral or Injected Steroids in 1 yr _____
Asthma Biologic Therapy?_____

I have a diagnosis of COPD/Emphysema: ▢ NO (go to next) ▢ YES: Name of my Lung doctor_____

I have cough or shortness of breath, or wheezing, or chest congestion: ▢ NO (go to next) ▢ YES: describe

_____

I have itching and/or a skin rash: ▢ NO (go to next) ▢ YES I have: ▢ Atopic Dermatitis/Eczema
▢ Hives or Swelling
▢ Contact Dermatitis/Allergy

Describe_____

I have stomach problems: ▢ NO (go to next) ▢ YES Describe _____

I have recurrent infections: ▢ NO (go to next) ▢ YES Describe _____

I have insect sting reactions: ▢ NO (go to next) ▢ YES: Type of Insect_____ | Sting Location_____
Type of Reaction: ▢ Local ▢ Large Local ▢ Systemic
Treatment Received: _____
Treated in the ER? _____

I have received the following vaccines: ▢ Flu _____ ▢ Pneumonia _____
▢ Others_____

I have been tested / treated for allergies in the past: ▢ NO (go to next) ▢ YES: Results _____

I have been treated with allergy shots (immunotherapy) ▢ NO (go to next)
▢ YES: Dr. Name-Location: _____

My Past Medical, Surgical, and Hospitalization History (list):_____
_____

My Family History of Allergies (list): _____

I have Pets: ▢ NO (go to next) ▢ YES: describe _____

Smoking History: Cigarettes? _____ Cannabis? _____

Alcohol or Illicit Drug Use? _____

Hobbies: _____ any allergic reactions seen? _____

FOOD ALLERGY/FOOD INTOLERANCE			DRUG ALLERGY/DRUG INTOLERANCE		
FOOD	REACTION FELT	FIRST TIME	DRUG	REACTION FELT	FIRST TIME

OTHER INFORMATION: Please write BRIEFLY why the patient is being seen (in the patient's own words)

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Notice of Privacy Policy

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

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 (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

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

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues required by law, Communicable Diseases:Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: 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 HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights– The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

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

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints –You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This Notice is effective as of April 15, 2003.

Privacy Officer: Allergy, Asthma, and Immunology Medical Group
Attention: Tamara Abarquez
5720 Ralston Street, Suite 205
Ventura, CA 93003
(805) 658-9500

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General Consent for Treatment, Release of Information, Insurance Coverage Policy, And Acknowledgment of receipt of The Notice of Privacy Policy

1. Consent: I hereby voluntarily request, consent to and authorize ALLERGY, ASTHMA AND IMMUNOLOGY MEDICAL GROUP and its staff to provide medical care including the administration of medications as deemed necessary and advisable.
2. Release of Information: I hereby authorize ALLERGY, ASTHMA AND IMMUNOLOGY MEDICAL GROUP to release to any third party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my patient records as is necessary in order to receive reimbursement for any services rendered relating to my treatment.
3. Physician Referral: I understand that if my health insurance is provided by a managed care plan, I am responsible for contacting my primary care physician and obtaining necessary referrals for any services rendered at this office. Failure to do so will result in my being financially responsible for said services.
4. Payment: I understand that I am responsible for any health insurance deductible and/or co-payments. I understand that I am financially responsible for the cost of services at the time they are rendered unless prior arrangements have been made. I understand that if my medical plan denies payment of services, I will be responsible for payment of said services.
5. Accuracy & Integrity: I hereby acknowledge the information I provided on the patient information form and patient history to be true and correct and completed to the best of my ability.
6. Treating Providers: ALLERGY, ASTHMA AND IMMUNOLOGY MEDICAL GROUP reserves the right, at all times, to designate the licensed provider who will perform any medical services requested of it, irrespective of whether or not the licensed provider so designated is an employee of this corporation.
7. No Guarantees: I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees are made as to the result of the care and treatment which I have hereby authorized.
8. Contact: I understand that ALLERGY, ASTHMA AND IMMUNOLOGY MEDICAL GROUP may contact me through any of the following methods for reminders about appointments, statements, insurance coverage, etc: phone call, text message, email, letter by mail or through the patient portal.
9. The Open Payment database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.
10. Child Treatment Authorization (optional):
    ▢ I authorize ALLERGY, ASTHMA AND IMMUNOLOGY MEDICAL GROUP to examine and/or treat my child (less than 18 years old) in my absences, while accompanied by someone appointed by me, the parent or legal guardian.
11. I understand that AI may be used to assist the providers in their visits with me for documentation purposes. There will be no identifying data. I can decline this at any time.

I have read this form or it has been read to me and I am satisfied that I understand the entire contents and significance of this form, and all my questions (if any) have been answered. Further, I understand that this consent will be deemed continuing and I am free to revoke my consent at any time.

I also acknowledge that I have read and received a copy of The Notice of Privacy Policy. I understand that ALLERGY, ASTHMA AND IMMUNOLOGY MEDICAL GROUP may refuse to evaluate and treat me if I do not consent to the use or disclosure of my health information as detailed in The Notice of Privacy Policy

_____ _____
Patient Name (PRINT) Date of Birth

_____ _____
Patient or Parent/Legal Guardian Signature Today's Date

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REQUEST FOR MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____

A mutual patient has come to our office for treatment.

Please send any of the following records that you feel pertinent to our workup.

1. Recent Progress Notes
2. Allergy Test Results
3. Laboratory Results
4. Imaging Results
5. Pulmonary Function Tests
6. Other:

_____

Kind personal regards,

Allergy, Asthma, and Immunology Medical Group

_____

Patient/Parent/Legal Guardian Signature