Center for Allergy and Asthma of Texas へようこそ

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当院に診療予約を頂き、ありがとうございます。来院くださった際に最適な診療を行うため、今までにかかったことのある病歴やご家族の病歴、お住まいの環境などについての質問票を作成しました。こちらをご記入の上来院下さい。

なお当日は現在服用されているお薬（ビタミン、ハーブ、サプリメント、市販薬なども含む）を全てお持ちになって下さい。

アレルギー疾患で受診の際、以下のリストにある薬は受診の **5 日前**から服用を中止して下さい。テストを正確に行う上で必要となります。

Actifed	Benadryl	Dramamine Durahist	Olopatadine Patanase	Tacaryl
Adapin	Biohist	Duratan Dura-vent	Pataday	Tandur
Advil Allergy	Bonine	Dytan	Patanol	Tavist
Advil PM	Bromged	Etrafon	Pediacare Pediatan	Theraflu
Ah-Chew	Brompheniramine	Excedrin PM	Periactin Phenergan	Triaminic
Alavert	Carbinoxamine	Extendryl	Polyhistine Promethazine	Triavil
Allegra	Cetirizine	Fexofenadine	Rescon	Trinalin,
Allerhist	Chlorpheniramine	Hydroxyzine	Robitussin -Cough, Cold & Allergy	Tylenol -Allergy/Cold/PM
Allertan	Chlor-Trimeton Clarinex	Ketotifen	Ronde	Unisom
Allerx	Claritin Clemastine	Lodrane Loratadine	Rutuss	Vistaril
Antivert	Comtrex	Levocetirizine	Ryna-12X, Rynatan	Xyzal
Arbinoxa	Contac Cyproheptadine	Marezine Meclizine	Ryneze	Zaditor
Astelin	Desloratadine	Nyquil	Semprex	Zonalon
Astepro	Dimenhydrinate	Optivar	Singlet	Zyrtec
Atarax	Dimetapp	Optimine	Sominex	
Atrohist	Diphenhydramine		Sudafed -Cold & Allergy	
Azelastine	Docylamine			
BC Cold				

血圧の薬、抗生物質、喘息の吸入薬など、リストに挙げられていない薬は服用を止めないでください。

ご不明な点やご質問はご連絡の上、ご相談下さい。

予約日時に来院できなくなった場合は、なるべく早くお電話下さい。予約で確保されていた時間が、他の患者さんの受診のためにオープンになります。少なくとも 24 時間前には連絡をお願いします。24 時間以内のキャンセルは 30 ドルのキャンセル料が発生することもありますので、ご注意下さい。

当院はアレルギーのクリニックで、喘息や他の呼吸器疾患の患者さんも来院します。香水、コロン、スプレーは、そのような患者さんの敏感な気道を刺激しかねませんので、使用を控えて来院して下さい。また、ナッツやナッツを含んだ食べ物を持ち込むことも、食物アレルギー患者さんにとっては危険ですので、おやめ下さい。

チェックインや受診の準備を整える時間を確保するため、予約時間の 15 分前にクリニックにおいで下さい。受診の際に話しておくべきことや質問事項などを紙に書いたリストをお持ちになると、効率よく受診できるでしょう。初診は 30 分から、状況によっては 2 時間かかることもあることをご承知おき下さい。

ご病気で体調を崩すのは、不便かつ不快な経験ですが、私どもは少しでも体調回復のお手伝いをし、安心かつ満足いただける医療サービスを提供できるよう努めてまいります。

医師　小川好子

日付:

Center for Allergy and Asthma of Texas

問診票

すべての情報のプライバシーは守られ、内容はカルテの一部になります。.

患者氏名		☐ 男　☐ 女	生年月日（月／日／年）：	
婚姻状況	☐ 独身　☐ パートナー有　☐ 既婚　☐ 別居　☐ 離婚　☐ 寡婦（夫）			
（該当すれば）紹介元医師:		Previous Allergy Doctor:		

健康全般に関する質問

今日来院された理由:	

現在の状況をご説明ください:

既往歴（今までにかかったことのある病気）

診断名	いつから

手術歴

年	手術の内容	病院名

上記手術以外の入院歴

年	内容	病院名

アレルギーの既往

ラテックスやゴムにアレルギーはありますか?　☐ yes　☐ no　　はいの場合、いつどのように:

薬物アレルギーはありますか? ☐ yes　☐ no
はいの場合、以下を記入下さい。

原因薬物	アレルギー反応の詳細	いつ起こりましたか？

食物、ハチやファイアーアント、造影剤などに対するアレルギー反応の既往があれば、ご記入ください。		
原因物質	アレルギー反応の詳細	いつ起こりましたか?

現在服用しているお薬を全て記入ください。 市販薬、目薬なども含めてお書き下さい。

薬剤名	用量	頻度	適応	服用開始時期
例: アスピリン	81mg	１日１回	心臓病	01/20/2012

過去に服用していた薬剤 （もっとスペースが必要な場合、空白の別紙をご用意頂き記入をお願いします）

生活習慣等に関する質問

運動の習慣	(内容)		（頻度）				
カフェイン	☐ なし	☐ コーヒー	☐ 紅茶	☐ コーラ			
	１日に飲む量（１日コップ XX 杯など）?						
アルコール	アルコール飲料を飲まれますか?				☐ はい	☐ いいえ	
	はいの場合、種類?						
	週に何回くらい飲まれますか?						
タバコ	タバコを吸いますか?				☐ はい	☐ いいえ	
	☐ タバコ – 箱/日		☐ 噛みタバコ - /日	☐ パイプ - /日	☐ 葉巻 - /日		
	☐ 喫煙年数	☐ 禁煙された場合その時期					
	間接喫煙はありますか?				☐ はい	☐ いいえ	
ドラッグ	現在ドラッグの使用はありますか?				☐ はい	☐ いいえ	
	今まで針を用いてドラッグを使用されたことはありますか?				☐ はい	☐ いいえ	
性生活	HIV 感染においてハイリスク要因がありますか?				☐ はい	☐ いいえ	
職業	（仕事の内容、引退されているか、学生かなど）						
	(定年退職されている場合、前職は？)						

家族歴

	年齢（逝去された場合は享年）		主な病歴		年齢		主な病歴
父親				**子供**	☐ 男 ☐ 女		
母親					☐ 男 ☐ 女		
兄弟姉妹	☐ 男 ☐ 女				☐ 男 ☐ 女		
	☐ 男 ☐ 女				☐ 男 ☐ 女		
	☐ 男 ☐ 女			**祖母** *母方*			
	☐ 男 ☐ 女			**祖父** *母方*			
	☐ 男 ☐ 女			**祖母** *父方*			
	☐ 男 ☐ 女			**祖父** *父方*			

住環境に関する質問

自宅	☐ アパート　☐一軒家, 築 ＿＿＿年　浸水したことが☐ ない ☐ ある, 時期? ＿＿＿＿＿＿＿＿			
床	居間:	☐ カーペット ☐ タイル/木の床	寝室:	☐ カーペット ☐ タイル/木の床
窓	居間:	☐ カーテン ☐ ブラインド ☐ 木製シャッター	寝室:	☐ カーテン ☐ ブラインド ☐ 木製シャッター
冷暖房	☐ セントラル A/C・暖房　☐ 窓取り付け式　☐ ヒーター			
A/C フィルター交換の頻度:	＿＿＿＿＿＿ 回／月			
ベッド:	☐マットレス　☐ ボックススプリング　現在のベッドの使用年数 ＿＿＿＿＿年　☐ ウオーターベッド アレルギー患者用のカバーを使っていますか?　☐ はい ☐ いいえ			
自宅にファン（天井付の扇風機）はありますか?	☐ はい ☐ いいえ	寝室にファンはありますか?		☐ はい　☐ いいえ
今までに浸水や雨漏りの被害がありましたか?				☐ はい　☐ いいえ
ペットの有無	(全てのペットの数と種類)			☐ 室内　☐ 屋外 ☐ 寝室
屋内の観葉植物の有無:	☐ いいえ ☐ はい　どこに置いていますか? ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿			
お子さんのケアについて:	週 ＿＿＿日 ☐ 学校以外の施設 ☐ その他		☐自宅　☐ 保育園、プレスクールなど	

過去のアレルギー検査について

施設名:	医師:	時期:
減感作療法を受けたことが: ☐ ない ☐ ある	治療期間? ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿	頻度: ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

最近以下の症状のうち、あてはまるものがあれば印を付けて下さい。									
一般	最近変化があった項目:	☐	体重	☐	眠り	☐	エネルギーレベル	☐	食欲
	☐ 熱								
頭	☐ 頭痛	どこが痛みますか:________________________				その他: __________________________________			
耳	☐ 感染	☐	耳鳴り ☐ 痛み			☐	きこえにくい		
目	☐ メガネ	☐	コンタクトレンズ ☐ 緑内障			☐	白内障 ☐ なみだ目		
	☐ 目のかわき	☐	かゆみ ☐ 赤目			☐	その他:______________		
鼻	☐ 鼻水	☐	鼻づまり ☐ 鼻血			☐	鼻のかゆみ ☐ くしゃみ		
	☐ 鼻手術	☐	副鼻くう炎 ___________ 回／年			☐	鼻ポリープ ☐ においがわからない		
のど	☐ のどの痛み	☐	かすれ声 ☐ いびき			☐	ものを飲み込みにくい ☐ せきばらい		
呼吸器	☐ 乾いたせき ☐ 痰を伴うせき ☐ ぜいめい ☐ 呼吸困難 ☐ 息切れ ☐ 運動すると息があがってしまう ☐ 喘息 喘息による救急外来受診 _______ 回 喘息による入院 ________ 回 ☐ 肺炎 ______ 回 ☐ 気管支炎 ________ 回 ☐ 結核 ☐ 気管支拡張症								
循環器	☐ 胸が痛む、押さえつけられているような感覚、苦しい ☐ 心臓の鼓動が早い								
消化器	☐ 胸やけ ☐ 逆流 ☐ はきけ ☐ 嘔吐 ☐ 消化不良 ☐ 食物不耐症								
筋骨格系	☐ 腰痛 ☐ 関節の痛み、こわばり ☐ 筋力低下 /筋肉のこわばり/腫れ								
神経	☐ 不安感 ☐ ストレス ☐ 睡眠パターンの変化 ☐ 不眠症 ☐ 過度に眠い								
内分泌	☐ 暑さに耐えられない、ほてり ☐寒さに耐えられない								

Center for Allergy and Asthma of Texas

患者登録票　（ローマ字でご記入下さい）

PATIENT INFORMATION

姓 Last Name:	名 First Name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	婚姻状況(該当するものに○) Single / Mar / Div / Sep / Wid 独身/ 既婚 /離婚/ 別居/ 寡婦(夫)

これは法律上の名前ですか ❑ はい Y　❑ いいえ N	いいえの場合、法律上の姓名 if no, legal name	旧姓(Maiden name):	生年月日 DOB (月/日/年) / /	年齢 Age	性別: ❑ M　❑ F

住所 address（英語表記でお願いいたします）：	ソーシャルセキュリティ番号 SSN.:	電話番号 phone number: 自宅 Home ( ) 携帯 Cell ( )
City:	State:	Zip Code:

職業 occupation:	勤務先 employer's address:	勤務先電話番号 work phone: ( )
紹介医師がいればそのフルネームと電話番号 referring physician's name and phone number		( )

IN CASE OF EMERGENCY　緊急時連絡先

名前 Name	患者さんとの関係 Relationship to patient	自宅電話番号 Home phone	勤務先電話番号 Work phone

INSURANCE INFORMATION　医療保険 (医療保険のカードを受付にご提示下さい)

請求先 Person responsible for bill		生年月日 DOB (月/ 日/ 年) / /	（もし上記と異なれば）住所 address	自宅電話番号 home phone ( )
職業 occupation	勤務先 employer's (company) name	勤務先住所 employer's address		勤務先電話番号 work phone ( )

医療保険をお持ちですか？ Do you have medical insurance?	❑ はい Yes	❑ いいえ No

医療保険について Insurance Info	医療保険会社名 Insurance Company Name				
保険契約者 Subscriber	契約者ソーシャルセキュリティー番号 Subscriber SSN	契約者生年月日 DOB (月/日/年) / /	グループ番号 Group #	ポリシー番号 Policy #	コペイメント :Co-pay $

保険契約者と患者との関係 Relationship	❑ Self 自身	❑ Spouse 配偶者	❑ Child 子供	❑ Other その他

(もしお持ちなら) 2 次医療保険会社名 Secondary insurance info	保険契約者名 Subscriber's name	グループ番号 Group#	ポリシー番号 Policy#

保険契約者と患者との関係 Relationship	❑ Self 自身	❑ Spouse 配偶者	❑ Child 子供	❑ Other その他

I （お名前をローマ字でご記入下さい）________________________________, hereby authorize Center for Allergy and Asthma of Texas to apply for benefits on my behalf for services rendered. I request payment be made directly to Center for Allergy and Asthma of Texas.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named insurance company. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

（参考　日本語訳）私（名前を下線部に記入）は Center for Allergy and Asthma of Texas が提供するサービス分のベネフィットを医療保険会社に請求することを了解し、支払いは保険会社から直接に Center for Allergy and Asthma of Texas にされるよう希望します。医療保険会社についての上記の情報は正確であり、医療情報も含め必要な情報は上記の医療保険会社に共有されることを了解します。この原文の代わりにこの許可の部分のコピーが使用されることを許可します。以上の了解はいつでも書面により取り消されることもあります。

Patient/Guardian signature　患者・あるいは患者の保護者署名　　　　*Date　月／日／年*

CENTER FOR ALLERGY AND ASTHMA OF TEXAS
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. Please review it carefully. Effective September 23rd, 2013

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Center for Allergy and Asthma of Texas*,* including its providers and employees (the "*Practice*").

I. **OUR OBLIGATIONS**.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess

the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. **Quality Assurance.** We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. **Utilization Review.** We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. **Credentialing and Peer Review.** We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

H. **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

I. **Appointment Reminders and Health Related Benefits and Services**. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone , e-mail and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

J. **Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

K. **Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

L. **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

M. **To Avert an Imminent Threat of Injury to Health or Safety.** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

N. **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

O. **Research.** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization

under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

P. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

Q. **Workers' Compensation.** We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

R. **Public Health Risks.** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

S. **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

T. **Legal Matters.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of healthcare providers, competency hearings on individuals, or claims over the payment of fees for medical services.

U. **Law Enforcement, National Security and Intelligence Activities.** In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

V. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

W. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

X. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

You have the right to request that your health information be communicated to you in a confidential manner, by alternative means or to an alternative location. Please send your written request to the office manager, whose address listed on the last page of this document. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing

us to send it to a particular place, the contact/address information. You are not required to provide an explanation for your request.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this

Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Center for Allergy and Asthma of Texas, PLLC
Attn: HIPAA Officer
12727 Kimberley Lane Suite 210
Houston, TX 77024
(832)900-1191

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:
____

____

Patient Name: __________________________________
(Please Print Name)

Patient Date of Birth: ____________________________

SIGNATURES:

Patient/Legal Representative: ____________________________________ Date:______________

If Legal Representative, relationship to Patient: ____

Center for Allergy and Asthma of Texas

Yoshiko Ogawa-Reel MD, FACP FAAAAI, FACAAI
Diplomate American Board of Allergy and Immunology, Diplomate American Board of Internal Medicine

FINANCIAL POLICY

Billing has become more and more complex due to changes in health care. If we have signed a participating agreement with your insurer, we will bill the insurer. You are responsible for your co-pay at the time of service, and any remaining balance from services rendered. If the patient is a minor, the adult accompanying the patient, and/or the patient's parent and/or legal guardian is responsible for payment at the time of services. We accept cash, checks, debit cards, Visa, MasterCard, and other most major credit cards. If you would like, you can make arrangements for your health care bills to be automatically charged to your credit card. There will be a $35.00 charge on returned checks.

It is ultimately your responsibility to understand your insurance benefits with your insurance carrier. Please check with your insurance carrier regarding your deductible for office visits (consultations with the Allergy Specialist) as well as a deductible for testing (Allergy Testing). These are often separate and you may be subject to a charge if you have not met your deductible for the year. Whether or not your insurance company pays in full, a portion or no portion of your medical bills is a matter between you and your insurance carrier. As a courtesy, we may obtain information regarding specific benefits covered and payable under your health insurance plan, but it is your responsibility to confirm the details of your health care plan coverage. If you are a member of a pre-paid health plan (HMO, PPO or other insurance) that requires preapproval for the visit, you are responsible to obtain the authorization. If the required referral is not obtained, you may be fully liable for the charges associated with the visit. Some insurance policies have complex rules about what is and is not covered. Center for Allergy and Asthma of Texas is always subject to the final determination of coverage by your insurance plan. Our office staff will be happy to answer any questions about the bill and to assist you. If we do not participate in your insurance plan, full payment is due at the time of your visit.

Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. There is a $25.00 late fee applied to your account if we do not receive full payment by the expected due date. Unpaid accounts beyond 90 days may be forwarded to a collection agency and/or attorney. All accounts must be current at the time of a clinic visit.

If the scheduled appointment cannot be kept, please let us know as soon as possible, at least 24 hours in advance. If you fail to keep your appointment or cancel in less than 24 hours, you may be subject to $30.00 cancellation fee. For special procedures such as Rush Immunotherapy, venom skin testing or a food challenge, we need special supplies and resources. We ask you to notify us immediately when you need to cancel the scheduled appointment for these procedures. If you cancel these special procedures less than 48 hours in advance, you will be charged $100.00 cancellation fee.

In most cases, you have the right to look at or get a copy of the health information that is about you, that we use to make decisions about you. If you would like to request copies, we will charge $25 for the first twenty page, and 50 cents for each page thereafter, along the actual costs of mailing, shipping or delivery.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Your name and signature on this sheet indicate that you have agreed to Center for Allergy and Asthma of Texas's Financial Policies.

I authorize payment of medical benefits for any services from Center for Allergy and Asthma of Texas. I understand that I am financially responsible for any amount not covered by my health insurance contract. I agree to promptly pay all charges and accept legal responsibility for any and all charges.

Patient Name :

____________________________________, ______________________________, _____________
(Last) (First) (Middle)

If patient is a minor:
Parent or Guardian Name :

____________________________________, ______________________________, _____________
(Last) (First) (Middle)

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other____________________

Patient signature (parent/guardian) : x ____

Date ____

Center for Allergy and Asthma of Texas

Yoshiko Ogawa-Reel, MD, FACP, FAAAAI, FACAAI

Diplomate American Board of Allergy and Immunology, Diplomate American Board of Internal Medicine

AUTHORIZATION TO SEND E-MAIL NOTIFICATION

I authorize Center for Allergy & Asthma of Texas to use my e-mail address for appointment reminders. I understand that my e-mail address will not be used for any other purposes and will be kept secure. Appointment reminders will be sent one week and one day prior to my appointment.

Patient E-mail: ____

Patient Name: ____

Patient Signature: ____

Date: ____