PATIENT INFORMATION SHEET

Please Circle One: Mrs. Ms. Miss Mr. Child Single Married Divorced Widowed

Patient Name:

Date of Birth Age SSN Male Female

Home Address City,St,Zip

Home Phone Cell #

Race □ White □ Asian □ Black/ African American □ Native Hawaiian or Other Pacific Islander

□ American Indian-Alaskan Native □ Other Race

Ethnicity □ Hispanic Latino □ Non-Hispanic or Latino Preferred Language: □ English □ Other:

EMAIL Driver's Lic. #

Preferred Means of Communication(Please Check One): □ Email □ Home Phone □ Cell Phone □ Mail □ Any

How did you hear about us? (Please Circle One) Physician Name: Community Event Name:

Flyer Browsing the web Friend Yelp Google Yahoo PPO Insurance Directory

FAMILY PHYSICIAN **PHYSICIAN PHONE #**

IF PATIENT IS A MINOR:

Father's Name: **Mother's Name:**

Birthday Birthday

Occupation Occupation

Employer Employer

Street Street

City,St,Zip Code City,St,Zip code

Phone # Phone #

EMERGENCY CONTACT **RELATIONSHIP** **PHONE #**

PRIMARY INSURANCE:

circle: EPO / HMO / PPO / POS

Primary Insured Name D.O.B. SS#

Insured's Employer Occupation

Insurance Company Name DL #

Insurance Address Effective Date

Insurance Ph. # Relationship to Subscriber

ID # on Card Group #

SECONDARY INSURANCE:

circle: EPO / HMO / PPO / POS

Primary Insured Name D.O.B. SS#

Insured's Employer Occupation

Insurance Company Name DL #

Insurance Address

Insurance Ph. # Effective Date

ID # on Card Group #

***** PLEASE READ *****

INSURANCE INFORMATION: I acknowledge that the physicians of Allergy and Asthma Assoc. may or may not be a part of the provider network for my insurance company and that it is my responsibility to verify that the providers are participating in my network. Please give your card(s) to the receptionist so we may keep a copy on file. All professional services rendered are charged to the patient/guardian. The patient is responsible for all fees regardless of insurance coverage. I hereby authorize Allergy and Asthma Assoc. to furnish all information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and that it is my responsibility to ask for an estimation of the costs of any tests being recommended/ordered prior to them being performed. My signature below indicates that I have read and agree to these said statements.

Signature: Date:

Allergy & Asthma Associates of Southern California
Leading-edge, personalized care you can trust

27800 Medical Center Road, Suite 244 • Mission Viejo, CA 92691
675 Camino de Los Mares, Suite 403 • San Clemente, CA 92673
15785 Laguna Canyon Road, Suite 100 • Irvine, CA 92618
Tel: (949) 364-2900 • Fax: (949) 365-0117
www.SoCalAllergy.com

William E. Berger, M.D. Warner W. Carr, M.D. Mark S. Sugar, M.D. Christina D. Schwindt, M.D. Faith R. Huang, M.D.
Diplomates of the American Board of Allergy and Immunology

PATIENT NAME:_____ **TODAY'S DATE:**_____
DATE OF BIRTH:_____ **SEX: M F AGE:**_____
EMAIL ADDRESS:_____ **PHONE:**_____
REFERRED BY:_____ **PCP:**_____

INSTRUCTIONS FOR COMPLETING HEALTH QUESTIONNAIRE: If you are unable to complete this form online or prefer to fill out a hard copy, please print and complete this document, bringing it with you when you arrive for your first appointment. This form is designed to help find the cause of your problem and is an essential part of your evaluation, aiding in the proper selection of tests and treatments, and allowing us to spend more time focusing on your important problems. When possible, please provide a start and stop date for all medical conditions as well as provide a check box in the Med Taken box if you are currently taking medication for that condition. If you have a condition that is not listed please add it in the OTHER section.

****PLEASE NOTE: No antihistamines, such as Claritin, Allegra, Zyrtec, or Benadryl for at least 72 hours before your appointment, as they interfere with allergy testing. Asthma medications are allowed if needed for wheezing and coughing. If you are unsure of any medication you are presently taking, please call our office for instructions. ****

CHIEF COMPLAINT: (The main reason you are here)

_____

_____

HISTORY OF PRESENT ILLNESS (Please provide a brief description of your current condition)

_____

_____

_____

_____

_____

Please List All Current Medications	Dosages

PATIENT NAME:_____ DOB:_____

Please indicate if you have **EVER** been diagnosed with any of the medical conditions listed below

Allergies

☐ Hayfever or Allergic Rhinitis (Stuffy, Runny, Itchy Nose, Sneezing)

Symptoms Worse: ☐ Indoors ☐ Outdoors ☐ Both

☐ Allergic Conjunctivitis (Red, Itchy Eyes)

☐ Food Allergy

List Each Food and Reaction:

_____

_____

_____

☐ Stinging Insect Allergy (Bee, Wasp, Hornet, Etc.)?_____

☐ Drug Allergies

List Each Drug and Reaction:

_____

_____

Eyes, Ears, Nose & Throat

☐ Sinus Infections ☐ Ear Infections

☐ Nasal Polyps ☐ Hearing Loss

☐ Bloody Nose ☐ Cataracts

☐ Tubes in Ears ☐ Glaucoma

Lungs/Pulmonary

☐ Asthma

If yes: □ Have you ever used oral steroids for Asthma/COPD?

Date:_____

☐ Have you ever been hospitalized Asthma/COPD?

Date:_____

☐ # of ER visits in the past year for Asthma/COPD #_____

☐ How many times per week do you use your rescue medication?

#:_____

☐ Pneumonia Date:_____ □ Pulmonary Embolism Date: _____

☐ Smoking Packs/Day____ Yrs of Smoking:_____ Date Quit:_____

Skin/Dermatologic

☐ Eczema ☐ Hives Other Rash:_____

Endocrine

☐ Diabetes ☐ Thyroid Disease

☐ Other Endocrine Problems:_____

Heart/Cardiovascular

☐ High Blood Pressure ☐ High Cholesterol

☐ Heart Attack ☐ Heart Murmur

☐ Angina or Chest Pain ☐ Arrhythmias

Digestive/Gastrointestinal

☐ Ulcer ☐ Irritable Bowel

☐ Acid Reflux or Heartburn ☐ Diarrhea

☐ Nausea or Vomitting ☐ Hepatitis

Genitourinary/Gynecolgical

☐ Urinary Tract Infections ☐ Genital Herpes

☐ Enlarged Prostate ☐ Hysterectomy

☐ Menopause

Rheumatologic

☐ Osteoarthritis ☐ Rheumatoid Arthritis

☐ Osteoporosis ☐ Other:_____

Neurologic

☐ Migraine Headaches ☐ Sinus Headaches

☐ Stroke ☐ Seizures

☐ Other Neurologic Disorder:_____

Psychiatric

☐ Depression ☐ Anxiety

☐ Bipolar Disorder ☐ ADD/ADHD

☐ Other Psychiatric Disorder:_____

Other Chronic Medical Conditions:

PATIENT NAME:_____ DOB:_____

Cancer (Please specify type):

Surgical Procedures (List any previous surgeries and dates)

Previous Evaluation

☐ Allergy Tested Before? Date:_____

☐ Received Allergy Injections? Date:_____

☐ Pulmonary Function Testing? Date:_____

Medications that made your symptoms better:_____

Medications tried but did not help:_____

Family History (Check all that apply & the relationship)

☐ Hayfever? Relationship:_____

☐ Asthma? Relationship:_____

☐ Sinus Problems? Relationship:_____

☐ Eczema? Relationship:_____

☐ Bronchitis? Relationship:_____

☐ Emphysema? Relationship:_____

☐ Cystic Fibrosis? Relationship:_____

☐ Diabetes? Relationship:_____

☐ Heart Disease? Relationship:_____

Social History

School:_____ Grade:_____

Occupation:_____

Do you smoke? ☐ Yes ☐ No ☐ Quit

Packs Per Day?_____ How many years?_____

Exposed to second hand smoke? □ Yes □ No

Do you drink alchohol? ☐ Yes ☐ No ☐ Quit

How many drinks per week?_____

Do you drink caffeine (Coffee/Tea/Caffeinated Soda)? ☐ Yes ☐ No

Type:_____ Cups/Day:_____

Do you use any illicit drugs? ☐ Yes ☐ No ☐ Quit

Type:_____

Environmental

☐ Carpet ☐ Smokers in the home

☐ Pets (If yes, select type) ☐ Cat ☐ Dog ☐ Other:_____

Review of Systems

Please indicate any **Current** problems in the following areas:

General

☐ Chills ☐ Fever ☐ Weightloss ☐ Fatigue

Eyes

☐ Change in vision ☐ Itchy ☐ Red ☐ Watery

Ears

☐ Ear Infection ☐ Decreased Hearing ☐ Ear Popping

Nose

☐ Congestion ☐ Runny Nose ☐ Sneezing ☐ Itchy Nose

☐ Sinus Infection ☐ Post Nasal Drip ☐ Seasonal Allergies

Throat

☐ Sore Throat ☐ Change In Voice

Respiratory

☐ Shortness of Breath ☐ Cough ☐ Pain With Breathing

☐ Wheezing ☐ Problems with exercise

Cardiovascular

☐ Chest Pain ☐ Palpitations ☐ Arrythmias

☐ Leg Swelling

Gastrointestinal

☐ Abdominal Pain ☐ GERD or Acid Reflux ☐ Diarrhea

☐ Food Allergy

Reproductive

☐ Penile Discharge ☐ Vaginal Discharge □ Breast Pain

☐ Breast Lump □ Sexual Dysfunction

Skin

☐ Hives ☐ Red Rash ☐ Itchy Rash ☐ Contact Allergy

PATIENT NAME:_____ DOB:_____

Review of Systems (continued)

Neurologic	**Psychiatric**
☐ Dizziness ☐ Headache ☐ Numbness ☐ Vertigo/Room Spinning **Musculoskeletal** ☐ Back Pain ☐ Joint Pain ☐ Muscle Aches	☐ Anxiety ☐ Depression ☐ Increased Stress **Other (Please Describe):**

PLEASE NOTE: ALL INFORMATION SUBMITTED ON THIS FORM IS CONSIDERED SECURE HEALTHCARE INFORMATION AND IS HELD IN THE STRICTEST CONFIDENCE, PROTECTING YOUR RIGHTS TO PRIVACY.

QUESTIONNAIRRE COMPLETED BY:_____
RELATIONSHIP TO PATIENT:_____
DATE COMPLETED:_____

FOR OFFICE USE ONLY
This history form has been reviewed and discussed in detail with the patient.

Physician Signature	Date

"NOTICE TO CONSUMERS: MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARDS OF CALIFORNIA, (800) 633-2322, WWW.MBC.CA.GOV"

William E. Berger, MD, CA Med Lic# C35918,
Board Certified in Pediatrics and Allergy and Immunology

Warner W. Carr, MD, CA Med Lic# A98901
Board Certified in Internal Medicine and Allergy and Immunology

Mark S. Sugar, MD, CA Med Lic# C32628
Board Certified in Pediatrics and Allergy and Immunology

Christina D. Schwindt, MD, CA Med Lic# G84295,
Board Certified in Pediatrics and Allergy and Immunology

Updated 12/23/2013

Allergy & Asthma Associates of Southern California

Faith R. Huang, M.D. CA Med Lic# A125987
Board Certified in Pediatrics and Allergy and Immunology

"NOTICE TO CONSUMERS: PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE PHYSICIAN ASSISTANTS COMMITTEE. (916) 561-8780, WWW.PAC.CA.GOV"

April N. Showalter, PA-C, CA Lic#21000
Sumit K. Singh, PA-C, CA Lic#23282

_____

Patient Signature Date

_____

Printed Patient Name

Updated 12/23/2013

Allergy and Asthma Associates of So. Cal.

(949) 364-2900

William E. Berger, M.D. · Warner W. Carr, M.D. · Mark S. Sugar, M.D.

Christina D. Schwindt, M.D. · Faith R. Huang, M.D. · April N. Showalter, PA-C · Sumit K. Singh, PA-C

Effective Date: 09/23/2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. 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 protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

5. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

7. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

17. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

21. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health

care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

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

OR
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**.
You will not be penalized in any way for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION
FOR
Allergy and Asthma Associates

William E. Berger, M.D. · Warner W. Carr, M.D. · Mark S. Sugar, M.D.
Christina D. Schwindt, M.D. · Faith R. Huang M.D. April N. Showalter, PA-C

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from Allergy and Asthma Associates a copy of the Notice.

_____
Patient's Name (Please Print)

_____
Signature

_____
Relationship To Patient

Date:_____

ALLERGY & ASTHMA ASSOCIATES

FINANCIAL POLICY

We appreciate the confidence that you have expressed in selecting us as your physicians, and we are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. If you have any questions about our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

Payment in full is required at the time of service for:

1. Patients without insurance (self-pay)
2. Patients who are not covered by one of our contracted insurance plans.
3. Patients who do not provide us with contracted insurance information
4. Patients with outstanding balances owed for co-pays, and deductibles as well as any non-covered services.

ALL COPAYS ARE DUE AT THE TIME OF SERVICE

We accept cash, personal checks, Visa & MasterCard
For Medicare & contracted insurance plans, we will bill all services at no charge as per the requirements of the insurance contract.

All returned checks may be subject to a $20.00 service charge. You may be responsible for other costs of collection as permitted by law.

If the patient is a minor (17 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined above.

Referrals

It is your responsibility to obtain any required referrals for treatment at, or prior to, the time of your visit. Patients seen or treated in our office, without prior authorization from their HMO group, are responsible for the full charge of the visit. If you need to use a specific lab or x-ray facility, you must notify the nurse before the service is rendered.
Services rendered by this office that are not a covered benefit of your insurance policy will be patient responsibility.

Our office staff will assist you in dealing with your insurance carrier, but it is your responsibility to know and understand your own insurance plans and provisions.

I authorize my insurance benefits to be paid directly to Allergy & Asthma Associates.
I authorize Allergy & Asthma to release any medical or other information to my insurance company if requested.

"NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov. "

_____
Signature & Date

Print Patient's Name_____

revised 6/24/14

Allergy & Asthma Associates of Southern California
Leading-edge, personalized care you can trust

27800 Medical Center Rd. Suite 244, Mission Viejo, Ca 92691
675 Camino De Los Mares Suite 403 San Clemente, CA 92673
15785 Laguna Canyon Rd. Suite 100 Irvine, CA 92618
T: (949) 364-2900 F: (949) 365-0117
www. SoCalAllergy.com

A strong odor can be a dangerous trigger to patients with asthma and allergies. Please do not wear perfumes or fragrant lotions when visiting our office. Also, while in our office you may not use nail polish, polish removers, glues or other items with strong odors.

Thank you for your cooperation!
Allergy & Asthma Associates

Allergy & Asthma Associates of Southern California
Leading-edge, personalized care you can trust

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Warner W. Carr M.D.
Mark S. Sugar M.D.
Christina D. Schwindt M.D.
Faith R. Huang M.D.

27800 Medical Center Rd. Suite 244, Mission Viejo, Ca 92691
675 Camino De Los Mares Suite 403 San Clemente, CA 92673
15785 Laguna Canyon Rd. Suite 100 Irvine, CA 92618
T: (949) 364-2900 F: (949) 365-0117
www SoCalAllergy.com

PARKING INFORMATION AND DIRECTIONS TO ALLERGY & ASTHMA ASSOCIATES

PARKING RATES

Between 0-20	Minutes	FREE
Between 20-60	Minutes	$ 3.00
Between 1-2	Hours:	$ 4.00
Between 2-3	Hours:	$ 5.00
Between 3-4	Hours:	$ 6.00 Maximum

DIRECTIONS

Our medical office is located at **27800 Medical Center Road, Suite 244 in Mission Viejo.** We are across the parking lot from Mission Hospital / Children's Hospital at Mission in the white brick medical office building.

From the 5 / 405 freeway exit Crown Valley Parkway and proceed East (left if Southbound, right if Northbound) to Medical Center Road. This is one stop light past the entrance to the Shops at Mission Viejo (formerly Mission Viejo Mall). Turn right on Medical Center Road and proceed up the hill. Turn left into the driveway for Mission Hospital and the Medical Offices. The medical offices are on your right and are numbered 1-3 starting at the street. Building 3 is at the far end of the lot. When you enter the building, go to the left side corridor for the elevator to the 2nd floor. For stairs take the right side corridor to the first door, go up one flight to the 2nd floor.
Suite 244 is located on the "bridge" connecting Building #2 and #3. There is ample parking at the front, side and back of Building 3.