ARCADIA Allergy & Asthma

4840 E. Indian School Rd. Suite 101
Phoenix, AZ 85018
Ph (480) 626-6600 Fax (480) 626-6604

S. Reed Shimamoto, MD • Neal Jain, MD

WELCOME TO ARCADIA ALLERGY & ASTHMA!

Thank you for choosing our practice. The providers and staff at Arcadia Allergy & Asthma strive to provide the highest quality care for patients affected by a variety of allergic and immune conditions including asthma, atopic dermatitis, food allergies, allergic rhinitis (hay-fever), hives, angioedema and immune deficiency syndromes. We believe in a patient-centered approach, where each patient is unique, and their management is individualized. We utilize an evidence-based concept and offer cutting-edge technology to tailor our treatment plans to fit our patient's needs. All of us at Arcadia Allergy & Asthma enjoy what we do and we hope it shows!

Your new patient visit will take about 1-2 hours. To avoid delays, please have all the New Patient paperwork completed through the patient portal prior to your initial visit. Bring your insurance card and a picture ID with you to your visit. Kindly arrive at the check in time. If you arrive late, you may be asked to reschedule. If you need to reschedule your appointment, please give us 24 hours notice. For visits that are missed without a 24-hour notice, you may be charged $25.00.

We are located on the North side of Indian School Rd., in the Arcadia Medical Plaza, suite 101.

If you have any records pertaining to your visit from a previous Allergist or your referring physician, please bring them with you.

We look forward to seeing you. If you have any questions prior to your appointment, please do not hesitate to call us at 480-626-6600.

Thank You

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NAME (Last, First, M.I)	**DOB:**

CHIEF COMPAINT (PLEASE CHECK ALL THAT APPLY)		
☐ Adverse drug reaction	☐ FPIES	☐ Reaction to insect stings/bites
☐ Angioedema (swelling)	☐ Headache	☐ Recurrent infections
☐ Asthma	☐ Immune deficiency	☐ Runny nose
☐ Atopic dermatitis (Eczema)	☐ Itching/itchy	☐ Sneezing
☐ Cough	☐ Itchy eyes	☐ Urticaria (hives)
☐ Environmental allergies	☐ Nasal congestion	☐ Wheezing
☐ Eosinophilic esophagitis	☐ Possible allergic reaction	Other, *please specify:*
☐ Food allergies/Intolerances	☐ Rash	

MEDICATION ALLERGIES	**REACTION**

FOOD ALLERGIES	**REACTION**

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)		
ALLERGY/IMMUNOLOGY	**ENDOCRINE**	**INTEGUMENTARY**
☐ Allergic rhinitis (Hayfever)	☐ Diabetes (Type 1 or 2)	☐ Chickenpox
☐ Anaphylactic reactions	☐ Hyperthyroidism	☐ Eczema
☐ Common Variable Immune Deficiency	☐ Hypothyroidism	☐ Urticaria
☐ Immunizations up to date	**ENT (Ears, Nose, Throat)**	☐ Psoriasis
☐ Primary immune deficiency	☐ Chronic ear infections	**MUSCULOSKELETAL**
☐ Previously seen an allergist:	☐ Chronic sinus infections	☐ Arthritis
If yes, who? _____	☐ Chronic adenoiditis	☐ Carpal tunnel syndrome
☐ Previously on Immunotherapy:	☐ Chronic tonsillitis	☐ Gout
If yes, how many years? _____	☐ Sleep apnea	☐ Fibromyalgia
CANCER	☐ Vocal cord dysfunction	☐ Tendinitis
If yes, what kind? _____	**EYE OR VISION**	**NEUROLOGICAL**
	☐ Cataracts	☐ Autism spectrum disorder
	☐ Corrective eyewear	☐ Dementia
CARDIOVASCULAR	☐ Glaucoma	☐ Epilepsy
☐ Abdominal aortic aneurysm (AAA)	**GASTROINTESTINAL**	**PSYCHIATRIC**
☐ Arterial stenosis (AS)	☐ Abdominal pain syndrome	If yes, please specify: _____
☐ Bradycardia/Tachycardia	☐ Eosinophilic Esophagitis	**RESPIRATORY**
☐ Congestive heart failure (CHF)	☐ Gastro-esophageal reflux disease (GERD)	☐ Asthma
☐ Deep vein thrombosis (DVT)		☐ Bronchitis
☐ Heart murmur	☐ Irritable bowel syndrome (IBS)	☐ COPD
☐ Hypertension (HTN)	☐ Peptic ulcer disease	☐ Pneumonia
☐ Myocardial infarction (MI)	**GENITOURINARY**	**OTHER**
☐ Mitral valve prolapse (MVP)	☐ Kidney disease/failure/stones	*Please specify:*
☐ Pacemaker	☐ Prostate disease	

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NAME (Last, First, M.I)	**DOB:**

SURGICAL HISTORY AND HOSPITALIZATIONS		
Year	*Type*	*Hospital*

FAMILY HISTORY: Please use the following key:
(M) Mother, (F) Father, (S) Sibling, (D) Daughter, (Sn) Son, (MGP) Maternal Grandparent, (PGP) Paternal Grandparent

☐ Please check if you're adopted	Diabetes (Type 1 or 2):	Latex allergy:
Allergic rhinitis:	Drug allergy:	Lung problems (COPD):
Anaphylactic reaction:	Food allergy:	Seizures:
Arthritis:	GERD (Reflux):	Sinus infections:
Asthma:	Headaches/Migraines:	Thyroid disease:
Autoimmune disorder:	Heart Disease:	*Other, please specify:*
Cancer:	Hypertension (HTN):	
Cystic fibrosis:	Hives or swelling:	
Dermatitis/Eczema:	Immune deficiency:	

SOCIAL HISTORY	
Marital Status	☐ Child ☐ Divorced ☐ Married ☐ Separated ☐ Significant Other ☐ Single ☐ Widowed
If child, patient lives with	☐ Both Parents ☐ Mother ☐ Father Other:
If child, who has custody	☐ Joint ☐ Primary custody is with Father ☐ Primary custody is with Mother
Smoking Status	☐ Former smoker ☐ Current smoker ☐ Never Smoked Are you exposed to secondhand smoke at home? Yes or No
Occupation	
Hobbies	

ENVIRONMENTAL HISTORY	
Current Home	☐ Apartment ☐ Condo ☐ House ☐ Mobile Home ☐ Townhouse ☐ Other
Setting	☐ Farm ☐ Rural ☐ Suburban ☐ Urban/City
Flooring	☐ Carpet ☐ Tile/Linoleum ☐ Wood
Air Conditioning/Heating	☐ Central A/C ☐ Swamp Cooler ☐ Wall Unit ☐ Wood Stove

PETS
☐ Bird ☐ Cat ☐ Dog ☐ Fish ☐ Gerbil/Guinea Pig ☐ Horse ☐ Reptile (Lizard, Bearded Dragon, etc.) ☐ Other:
My pet(s) live: ☐ Inside ☐ Outside ☐ Sleeps in bedroom

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NAME (Last, First, M.I)	DOB:

CURRENT MEDICATIONS Please list all medications, including those taken "as needed"		
NAME (E.g.: ZYRTEC)	STRENGTH (E.g.:10mg)	DOSE/FREQUENCY (E.g.: 1 tablet daily)

REVIEW OF SYSTEMS Please check all that apply within the last 2-6 months		
CARDIOVASCULAR	**GASTROINTESTINAL**	**NEUROLOGICAL**
☐ Chest pain	☐ Abdominal pain	☐ Numbness/Tingling
☐ Heart palpitations	☐ Blood in stool	☐ Stroke
☐ Hypertension	☐ Constipation	☐ Tremors
EARS, NOSE, THROAT (ENT)	☐ Diarrhea	**PSYCHIATRIC**
☐ Itchy nose, sneezing, runny nose	☐ Heartburn	☐ Agitation
☐ Frequent ear infections	☐ Nausea	☐ Anxiety
☐ Frequent sore throats	☐ Recent loss of appetite	☐ Memory loss
☐ Nasal congestion	☐ Vomiting	☐ Mood disorder
☐ Nasal polyp(s)	**GENERAL**	☐ Nervousness
☐ Post-nasal drip	☐ Chills	☐ Problems concentrating
☐ Hearing loss	☐ Dizziness	☐ Stress
☐ Ringing in ears	☐ Fatigue	**RESPIRATORY**
☐ Snoring	☐ Fever	☐ Chest congestion
☐ Trouble swallowing	☐ Headache/Migraines	☐ Chest tightness
ENDOCRINE	☐ Weight loss	☐ Cough
☐ Cold intolerance	☐ Weight gain	☐ Difficulty breathing
☐ Decreased energy/endurance	**GENITOURINARY**	☐ Pneumonia
☐ Easily fatigued	☐ Bed wetting	☐ Shortness of breath
☐ Frequent thirst	☐ Blood in urine	☐ Wheezing
☐ Heat intolerance	☐ Frequent urination	**SKIN**
EYE OR VISION	☐ Frequent UTIs	☐ Eczema
☐ Blurred vision	☐ Pain when urinating	☐ Hives
☐ Double vision	**MUSCULOSKELETAL**	☐ Rash
☐ Eye pain	☐ Joint pain or stiffness	☐ Itching
☐ Itchy eyes	☐ Weakness of muscles/joints	☐ Psoriasis
☐ Watery eyes		

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ECZEMA CLINIC

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NAME (Last, First, M.I)	**DOB:**

When was the patient first diagnosed with eczema (atopic dermatitis)? _____

Please indicate the date and performing office if any of the following tests have been performed:

Environmental Skin Testing
Approximate date testing was performed: _____

Physician: _____

Phone number: _____ Fax: _____

Address: _____

Please ensure your records have been sent to our office **prior to your appointment date**

Food Allergy Skin Testing
Approximate date testing was performed: _____

Physician: _____

Phone number: _____ Fax: _____

Address: _____

Please ensure your records have been sent to our office **prior to your appointment date**

Patch Testing
Approximate date testing was performed: _____

Physician: _____

Phone number: _____ Fax: _____

Address: _____

Please ensure your records have been sent to our office **prior to your appointment date**

Skin Biopsy
Approximate date testing was performed: _____

Physician: _____

Phone number: _____ Fax: _____

Address: _____

Please ensure your records have been sent to our office **prior to your appointment date**

All relevant records must be received by our office **prior** to your appointment. If you are completing this paperwork prior to your appointment and would like us to request your records from any of the above physicians, please sign and date below.

_____ _____

Signature of parent/guardian Date

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NAME (Last, First, M.I)	**DOB:**

Have you (or your child) ever been treated for a skin infection or given antibiotics to treat your eczema? YES / NO

Please indicate which, if any, topical eczema therapies you (or your child) have used before:

Low Potency Corticosteroids		
Medication	Duration of Use	Did you respond to treatment?
Hydrocortisone		
Aclometasone diproprionate		
Desonide		
Flucinolone acetonide		
Mid-Potency Corticosteroids		
Medication	Duration of Use	Did you respond to treatment?
Fluticasone propionate		
Fluocinolone acetonide cream		
Betamethasone valerate		
Mometasone furoate cream		
Triamcinolone acetonide		
High Potency Corticosteroids		
Medication	Duration of Use	Did you respond to treatment?
Betamethasone diproprionate		
Mometasone furoate ointment		
Clobetasol		
Halobeasol propionate		
Fluocinolone acetonide ointment		
Topical Calcineurin Inhibitors		
Medication	Duration of Use	Did you respond to treatment?
Protopic (Tacrolimus)		
Elidel (Pimecrolimus)		
PDE-4 Inhibitor		
Medication	Duration of Use	Did you respond to treatment?
Eucrissa (Crisaborole)		

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NAME (Last, First, M.I)	**DOB:**

If you have used a medication for eczema which was not listed on the last page, please list it here. _____

_____

_____

What non-medicated topical moisturizers have you (or your child) used? _____

_____

Do you use any homeopathic topical treatments or essential oils on your (or your child's) skin? If so, list below:

_____

_____

Please indicate which, if any, oral immune suppressant medication therapies you (or your child) have used before:

Medication	Duration of Use	Did you respond to treatment?
Cyclosporine		
Methotrexate		
Azathioprine		
Mycophenolate mofetil		
Prednisone or other systemic corticosteroids		

Have you (or your child) ever been treated with a biologic therapy such as Dupixent (dupilumab) or Xolair (omalizumab)?

Medication	Duration of Use	Did you respond to treatment?
Dupixent (dupilumab)		
Xolair (omalizumab)		

How frequently do you (or your child) take baths? How long do you soak? _____

Please indicate what bath products you use:

a. Soap: _____
b. Shampoo: _____
c. Conditioner: _____
d. Bath Additives: _____

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NAME (Last, First, M.I)	**DOB:**

Please list any diagnosed food allergies:

Food	Reaction to food

Which food(s) do you (or your child) currently avoid? _____

_____

Are you interested in participating in clinical trials? YES / NO

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PATIENT INFORMATION SHEET

First Name:_____Middle Initial:_____Last Name:_____

Date of Birth:_____Social Security#_____Sex: Male_____Female_____

Address:_____

Home Phone:_____Cell Phone:_____E-Mail:_____

Employer:_____Address:_____Phone:_____

Occupation:_____Whom to notify in case of emergency?_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email:_____Preferred method of contact:_____

Pharmacy Name:_____Phone:_____Cross Roads:_____

Race: □ Caucasian, □ African American, □ American Indian, □ Asian, □ Hispanic

Ethnicity: □ Caucasian, □ African American, □ Native American, □ Asian, □ Hispanic, □ Pacific Islander, □ Eastern Indian

Preferred Language: □ English, □ Spanish, □ ASL, □ Other_____

Spouse Name:_____Phone:_____Cell:_____

Pediatric Patients (under 18)

Name of Father:_____ Phone:_____Cell:_____

Email:_____Address:_____

Employer Name, Address & Phone:_____

Name of Mother:_____ Phone:_____Cell:_____

Email:_____Address:_____

Employer Name, Address & Phone:_____

Primary Care Physician_____Office Phone:_____

Address:_____Referred By:_____

Primary Insurance:_____Address:_____

ID #_____Group #_____Policy Holder' Name:_____

Policy Holder's DOB:_____Policy Holders SS#_____

Secondary Insurance:_____Address:_____

ID #_____Group #_____Policy Holder' Name:_____

Policy Holder's DOB:_____Policy Holders SS#_____ I authorize the release of protected health information for the purpose of treatment, payment, and health care operations. I authorize fax transmission of medical records, if necessary. I authorize payment of insurance benefits to Arcadia Allergy & Asthma. I understand that I am financially responsible for the charges not covered by my insurance**.** The HIPPA Privacy Notice for Arcadia Allergy & Asthma has been given to me**.**

Patient/Responsible Party Signature:_____Date:_____

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OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. A copy of your current insurance card and verification of your address is required at **every visit**. You are responsible for ensuring your address and insurance on file are correct. You are responsible for any unpaid balances or fees that arise if this information is not updated.

2. As outlined by your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances. Payment of co-pays and deductibles is due at time of service based on benefit information provided to us by your insurance company. If you are unable to pay your co-payment and any other patient responsibility at time of service, you will be asked to reschedule.

3. We will submit to your secondary insurance, as a courtesy to you. If the secondary does not cover the balance owed from the primary insurance, you are responsible for any balance on the account.

4. It is your responsibility to understand your insurance benefit plan, and to know if a written referral or authorization is required to see specialists. Often a preauthorization is required prior for procedures. **We strongly urge** you to contact your insurance company prior to your appointment for detailed benefit coverage, policy limitations, and non-covered services.

5. If our physicians do not participate in your insurance plan, payment in full for your visit is due at the time of your visit.

6. If you don't have insurance, payment in full for your office visit is due at the time of the visit.

7. Missed appointments not only impact you, but other patients waiting to be seen. If you are unable to keep your appointment, we require 24 hours notice to cancel so we can open this time up for other patients to schedule. If you do not call within the 24 hours you are subject to a $50.00 fee. A second missed New Patient appointment will be subject to a $100.00 fee.

8. If payment arrangements have not been made with our billing department prior, patients with outstanding balances over 60 days will not be scheduled for appointments and will not be provided refills until balance is paid in full or payment plan has been set up with our billing department.

9. If payment arrangements have not been made with our billing department prior, any balance over 90 days is subject to being placed with our collection agency. An additional fee of 25% of the outstanding balance will be applied to all balances placed with our collection agency.

10. A $25.00 fee will be charged for any checks returned, along with any bank fees incurred.

11. If you are requesting a copy of Medical Records, there will be a .50 cent per page fee.

12. Should you have forms that need to be completed and signed by the Physician or staff you may be subject to a $25.00 fee.

I have read and understand **Arcadia Allergy & Asthma** Financial Policy and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____DOB_____

Responsible party member's name_____ Relationship_____

Responsible party member's signature_____ Date_____

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Patient Disclosure Form

Since HIPAA legislation became effective in April of 2003, we are no longer allowed to automatically assume that our patients authorize us to give out information about their care to anyone other than themselves. Not even to parents of 18 year old patients, grandparents that baby-sit or nannies. For that reason, please list the names of all family members, friends, school nurse, etc. that you give us permission to release information to about you or your child's care. If anyone not listed on this form calls or otherwise asks us for information about you or your child (even for information as basic as when your next appointment is or how to give your child's medication), we will have to refuse to give them that information until we get your expressed permission to do so.

I authorize and agree that Arcadia Allergy & Asthma may disclose my Protected Health Information to the following:

	Name	**Relationship**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Authorization for Disclosure of Information

I give permission to leave a detailed voice mail regarding:
☐ All information regarding my medical care at Arcadia Allergy & Asthma

Or only the following:
☐ Medication/pharmacy information
☐ Lab/test/X-ray results
☐ Information regarding upcoming testing/appointments/allergy injections
☐ Insurance/billing information
At the following telephone number(s):_____

I acknowledge and agree that Arcadia Allergy & Asthma may disclose my Protected Health Information to the persons or telephone number set forth on this form, unless and until I object to such disclosure, which will be provided in writing to Arcadia Allergy & Asthma.

Patient Name:_____Dob:_____

Date:_____ _____

Signature of Patient/Patient's Personal Representative/Legal Guardian

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Policy for Appropriate Conduct

It is the intent of Arcadia Allergy & Asthma to provide a safe workplace for employees and to provide a comfortable and secure atmosphere for patients and others with whom we do business. In order to achieve this, we treat all of our patients with dignity and respect, and we ask the same of our patients.

It is the expectation of our office that patients will adhere to the following appropriate behaviors including, but not limited to the below list:

- Using a normal tone of speech when speaking with staff
- Treating all staff with dignity and respect whether in the clinic or on the phone
- Using appropriate language when speaking in the clinic or on the phone
- Being respectful of the practice's property and supplies

Depending on the specific circumstances, Arcadia Allergy & Asthma may deem certain behaviors in violation of this policy. Violation of this policy may result in verbal counseling and/or discharge from the practice.

By signing below, I acknowledge the above information and agree to abide by these guidelines for appropriate conduct.

_____ _____

Patient Name DOB

_____ _____

Patient/Parent/Legal Guardian Signature Date

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NOTICE OF PRIVACY PRACTICE

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.

If you have any question about this notice, please contact the Privacy Officer at Arcadia Allergy & Asthma.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services your receive at Arcadia Allergy & Asthma. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices concerning medical information about you; and
- follow the terms of this notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

- **For Treatment**. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurse, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan.
information about you so that they will pay for your treatment

- **For Health Care Operations**. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may also combine medical information about many Arcadia Tan Allery & Asthma patients to decide services our Practice should offer, what services are not needed and whether certain new treatments are effective. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.
- **Appointment Reminders, Treatment alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
- **For Payment**. We may use and disclose Health Information so that we or others may bill and receive payment from
- **Individuals Involved In Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
- **Research**. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
- **As Required By Law**. We will disclose Health Information about you when required to do so by federal, state or local laws.
- **To Advert a Serious Threat to Health or Safety**. We may use and disclose Health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **For All Other Uses and Disclosures**. All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization.

Special Situations

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information about you as required by military command authorities. We may also release Health Information to the appropriate foreign military personnel if you are a member of a foreign military.

Workers' Compensation. We may release Health Information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information about you for public health activities. These activities general include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products that 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 authorized and required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information (PHI)to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the results of criminal conduct;
- About criminal conduct on our premises; and
- In emergency circumstances to report a crime; the location or the crime or victims; or identify, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health 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 Health Information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUITY TO OBJECT AND OPT OUT.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information (PHI) that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek you PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we can practically do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES.

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1) Uses and disclosures of Protected Health Information for marketing purposes; and
2) Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice of the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy Health Information, you must make your request, in writing, to our Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal benefit program. We may deny you request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format, known as electronic medical records or electronic heath records, you have the right to request that an electronic copy of your records be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such a form or format. If the Protected Health Information is not readily producible in the form or format you requested your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have 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 or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Account of Disclosures. You have the right to request a list of certain disclosures we made of Health Information purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we may disclose to someone involved in your care or the payment for your care, like a family member or friend. To request a restriction, you must make your request, in writing to our Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health are item or service for which you have paid us “out of pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Out-of- Pocket Payments. If you paid out-of-pocket, in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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. You must make your request in writing to our Privacy Officer. Your request should be specific on how or where you wish to be contacted. We will accommodate reasonable requests.

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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact our Privacy Officer. You may obtain a copy of this notice at our website Arcadiawww.arcadiaallergy.com

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

Effective Date 6-1-2014

ARCADIA Allergy & Asthma

4840 E. Indian School Rd. Suite 101
Phoenix, AZ 85018
Ph (480) 626-6600 Fax (480) 626-6604

S. Reed Shimamoto, MD • Neal Jain, MD

ACKNOWLEDGEMENT

I, _____, (patient name) acknowledge that I have received a copy of Arcadia Allergy & Asthma's Notice of Privacy Practice, effective May 1, 2014.

Patient/Parent/Legal Guardian Signature: _____

Date: _____

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S. Reed Shimamoto, MD ● Neal Jain, MD

Skin Testing Patient Information Handout

- Discontinue antihistamine tables/liquids/nasal sprays/eye drops for **7 days** prior to testing (see full list on back).

- The skin testing will take about 30 minutes, **so you must arrive 30 minutes prior to your scheduled appointment in order for a nurse/medical assistant to place and read your skin test.** You will see the provider after the testing for your scheduled appointment to review the results and set up a treatment plan. Your total time in the office may be 90 minutes or so. If you do not arrive 30 minutes prior to your appointment with the provider to have the skin test placed, we may need to reschedule your appointment for another day.

- Children under 18 must be accompanied by a legal guardian during the entire length of the appointment.

- Please do not bring other children with you to the testing as space in the room is limited.

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Antihistamines to be Stopped for Allergy Testing

Instructions: Stop the following 5-7 days before testing

Actagen
Actifed
Acrivastine
Allegra (any)
Allerclear
Allerfrin
Alertec/Aller-Tec
Aller-Fex
Antivert
Atarax
Benadryl
Bromphed
Brompheniramine
Cetirizine
Chlorpheniramine
Chlor-trimeton
Clarinex (any)
Claritin (any)
Clemastine
Cyproheptadine
Deconamine
Dimenhydrinate
Dimetane
Dimetapp
Dipenydramine
Doxepin
Dramamine
Drixoral
Duravent-DA
Fexofenadine
Histavent-LA
Histex
Hydroxyzine
Meclizine
Ominihist-LA
Ornade
Pedicare
Periactin
Phenergan
Poly-histine
Promethazine
Rondec
Rynatan
Ryna-12
Rynatuss
Semprex-D
Tanafed
Tavist
Triaminic
Triaminicol
Trinalin
Triprolidine
Tussi-12
Tussionex
Vistaril
Wal-Fex
Wal-Tin
Wal-Zyr
Xyzal
Zyrtec

Nasal Sprays
Astelin
Astepro
Azelastine
Patanase

Eye Drops
Pataday
Patanol
Olopatadine
Optivar
Zaditor

Other
Benzodiazepines
Lunesta
Trazodone
Xanax
*Contact your prescribing physician prior to discontinuing the medications listed under 'Other'.

Also stop any medication that has the words SINUS, ALLERGY OR "HIST"

Please be advised that many over the counter medications have antihistamines in them (i.e. sinus, headache, sleep or cough medicines). These medications will need to be stopped 5 days prior to the testing as well. If you are not sure if the medication you are taking contains an antihistamine, please call our office for advice.

DO NOT stop any other medications especially for the heart, liver, lung or other conditions. If for some reason you cannot stop the allergy medication do not worry. We will see you for the consultation and then can reschedule for the testing another time.