Lakeshore Allergy PC

Board Certified in Allergy, Asthma and Immunology

New Patient Intake Form

Please print clearly.

Patient Name: _____

Date of Birth: _____ **Age:** _____ **Sex:** **Social Security Number:** _____

Address: _____ **Apt #**: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: **Home Phone:** _____ **Cell Phone:** _____

Email Address: _____

Our organization will use the patient's address and telephone numbers for communication unless an alternative form of communication is requested. If alternative form of communication is preferred, please specify: _____

Marital Status:

Race: _____ **Ethnicity:**

Preferred Language: _____

Primary Physician: _____ **Referring Physician:** _____

Preferred Pharmacy: _____ **Address**:_____ **Phone**:_____

Emergency Contact #1: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact #2: _____ **Relationship:** _____ **Phone:** _____

For Patients Under 18: Parent or Legal Guardian Names:

Mother: _____ **Father:** _____

Patient Name: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Effective Date:** _____ **Specialist Copay:** $_____

Insurance ID: _____ **Group #:** _____

Subscriber Name: _____ **Employer:** _____ **SSN:** _____

Secondary Insurance: _____ **Effective Date:** _____ **Specialist Copay:** $_____

Insurance ID: _____ **Group #:** _____

Subscriber Name: _____ **Employer:** _____ **SSN:** _____

BETA BLOCKER SCREENING

Are you taking any of the following medications? Please check or circle.

- ☐ Betachron (propranolol)
- ☐ Betapace & Betapace AF (sotalol)
- ☐ Blocadren (timolol)
- ☐ Brevibloc (esmolol)
- ☐ Gencaro (bucindolol)
- ☐ Bystolic (nebivolol)
- ☐ Cartrol (carteolol)
- ☐ Coreg (carvedilol)
- ☐ Corzide, Corgard (nadolol)
- ☐ Hemangeol (propranolol)
- ☐ Inderal (propranolol)
- ☐ Inderide (propranolol)
- ☐ Innopran XL (propranolol)
- ☐ Kerlone (betaxolol)
- ☐ Levatol (penbutolol)
- ☐ Lopressor (metoprolol)
- ☐ Normodyne (labetalol)
- ☐ Normozide (labetalol)
- ☐ Pronol (propranolol)
- ☐ Sectral (acebutolol)
- ☐ Sorine (sotalol)
- ☐ Sotylize (sotalol)
- ☐ Tenoretic (atenolol)
- ☐ Tenormin (atenolol)
- ☐ Timolide (timolol)
- ☐ Toprol (metoprolol)
- ☐ Trandate (labetalol)
- ☐ Visken (pindolol)
- ☐ Zebeta (bisoprolol)
- ☐ Ziac (bisoprolol)

By initialing, I certify that I am not currently taking any of the above medications: _____

Patient Name: _____

CURRENT MEDICATIONS

Please list any medications you are taking, along with dosage and frequency. If more space is required, please continue the list at the bottom of the page. You may also provide a copy of your medication list.

1. **Medication:** _____ **Dosage:** _____ **Frequency:** _____
2. **Medication:** _____ **Dosage:** _____ **Frequency:** _____
3. **Medication:** _____ **Dosage:** _____ **Frequency:** _____
4. **Medication:** _____ **Dosage:** _____ **Frequency:** _____
5. **Medication:** _____ **Dosage:** _____ **Frequency:** _____

ALLERGIES

Please list known allergies to medications or foods. If no known allergies, please leave blank. If more space is required, please continue the list at the bottom of the page. You may also provide a copy of your allergy list.

1. **Medication/Food:** _____ **Reaction:** _____
2. **Medication/Food:** _____ **Reaction:** _____
3. **Medication/Food:** _____ **Reaction:** _____
4. **Medication/Food:** _____ **Reaction:** _____
5. **Medication/Food:** _____ **Reaction:** _____

PAST MEDICAL HISTORY

Please list relevant medical history. You may also provide a list from your primary care doctor.

_____
_____
_____
_____
_____

Patient Name: _____

FAMILY MEDICAL HISTORY

Please check diagnoses and affected family member(s)

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
DIAGNOSES:						
Drug Allergy						
Food Allergy						
Bee Allergy						
Asthma						
COPD						
Cystic Fibrosis						
Emphysema						
Sleep Apnea						
Tuberculosis						
Cancer						
Type of Cancer						
Diabetes						
Thyroid Disease						
Heart Attack						
Hypertension						
Stroke						
Crohn's Disease						
Diverticulitis						
Heartburn/Reflux						
Lupus						
Psoriasis						
Rheumatoid Arthritis						
Bipolar Disorder						
Depression						
Other_____						

TRAVEL HISTORY

Has there been any recent travel outside of the country within the last 3 months? If so, please list:

Dates: _____ Location: _____ Any illness related to that travel? _____

SOCIAL & ENVIRONMENTAL HISTORY

LIVING ENVIRONMENT

Please circle which description describes your situation best.

Type of Home:

Age of Home: _____ Basement:

Heating Type:

Cooling Type:

Age of Mattress: _____

Indoor Pets: **_____ Outdoor Pets**: **_____**

OCCUPATION

Occupation: _____ Work Environment:

Do you have worsening symptoms at work? If so, please describe: _____

_____

TOBACCO HISTORY

Do you have a history of tobacco exposure?

Have you ever used tobacco products?

If yes, how many cigarettes or pods per day? _____

Do you still smoke? Year quit: _____

PATIENT CONSENT TO FINANCIAL AND OFFICE POLICIES

Please see attached documents on the following pages to review our financial policy, office policy, and Notice of Privacy Practices.

By signing below, I acknowledge that I have read and understand the Financial Policy and Office Policy (as stated on the following pages) of Lakeshore Allergy, PC.

In addition, this Organization has published a HIPAA 'Notice of Privacy Practices' (NPP) as stated on the following pages. I have been informed and provided a copy of the NPP. ***Please initial one selection below:***

I have been provided a copy of the Notice of Privacy Practices _____
I have previously been provided a copy of the Notice of Privacy Practices _____
I decline to read the Notice of Privacy Practices _____

Signature of Patient/Guardian: _____ Date: _____
Printed Name: _____ Relationship to Patient (if applicable): _____

PATIENT CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The Patient hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by Lakeshore Allergy PC in order to carry out treatment, payment and healthcare operations. The Patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information, the Patient has a right to review this document prior to signing this consent.

This Organization has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the Patient has a right to obtain a copy of the revised Notice.

Patient acknowledges and agrees that this Organization may disclose the Patient's protected health information and/or medical record - billing information to the following individual(s) who are the Patient's family members, guardians, legal representatives, healthcare surrogates or have power of attorney on behalf of the patient.

The people listed below may receive protected health information and/or medical records or billing information from this Organization. If no people apply, please leave blank.

1. Person's Name _____ Relationship _____ Phone _____
2. Person's Name _____ Relationship _____ Phone _____
3. Person's Name _____ Relationship _____ Phone _____

The Patient agrees that this Organization may disclose the following types of information if contained in the Patient's medical or billing records: *please circle the appropriate categories*

☐ HIV/AIDS ☐ Substance abuse info ☐ Pregnancy info (if <18 years)
☐ Mental Health info ☐ Sexually transmitted infection info

Financial Policy

Insurance

Your insurance carrier will be billed according to our contract as a courtesy to you; however, **payment for deductible and copay is due at the time of service.** This includes all office visits, procedures, and injections. Please remember that your insurance coverage is a contract between you and your insurance company and not a substitute for payment. Failure to provide us with your social security number may make it impossible for us to speak to your insurance regarding your claim. Please check with your insurance company as to what your copay, deductible, and coinsurance are. Should your insurance change, please notify us prior to your next appointment.

Prior Authorizations

Some insurance companies require prior authorizations for **procedures** done in the office. This will be the **patient's responsibility** to check with their insurance prior to their visit to avoid possible higher deductible and copay charges.

Self-Pay Accounts/Plans We Do Not Participate With

Self-pay accounts are patients that have no insurance coverage, have not met their deductible, or are covered by insurance plans with which we do not participate. **Payment must be made at the time of service**. If this is not possible, please discuss the situation with the billing department before your scheduled appointment.

No Show/Cancellation Policy

We kindly ask that you provide 24 hours notice if you are unable to keep a scheduled appointment. Failure to do so may result in a "no show/late cancellation" fee of $50 for new patient appointments or $25 for established patients. Payment of this fee will be required prior to the rescheduling of a new appointment. Multiple missed appointments may result in discharge from our practice. Exceptions will be made on a case by case basis.

Payment Methods

For your convenience, we accept the following methods of payment: cash, personal check, Visa, MasterCard, Discover, and American Express.

Forms

If you need forms filled out, there may be a charge of $10.00 for school forms or $25.00 for FMLA forms or any letter that Lakeshore Allergy PC needs to draft. If you need copies of records from our office, there may be a fee of $0.10 per page.

Authorization & Release

By signing above, I authorize payment of medical benefits be made to Lakeshore Allergy PC. I understand the financial policy as stated above and accept the personal responsibility for payment of covered and non-covered services. I authorize the release of any medical or other information necessary to process my claims.

Office Policy

Office Information

Please do not eat or drink in our clinic (closed water bottles are ok) since other patients may have food allergies. Please avoid wearing strong perfumes or fragrances in our office since it is a common asthma trigger. Shoes and proper attire are required in our office. We do not have a public restroom, so please use the restroom at the end of the hall prior to your injection or visit.

Please refrain from speaking on your phone or watching videos with volume while in the waiting room. If you need to make a call, please step into the hallway but do not leave the building.

Consent from a parent or legal guardian is required in order for others to bring a minor patient for an injection or office visit. **No exceptions**. It is the parent/guardian's responsibility to sign a consent form prior to the appointment. Please speak with our front desk for a form to complete.

Injection Information

It is difficult to transfer allergy shots from another office. We may require updated testing via skin or blood, so please bring results if you have been tested recently. Due to differences in allergy extracts or styles of mixing, patients often need to start immunotherapy over to safely continue shots. Exceptions are made on an case-by-case basis and we will discuss further at your first appointment, if applicable.

Please review your financial consent form provided to you separately since billing may vary based on style of immunotherapy and your specific insurance plan.

All allergy shot appointments require appointments. Remember there is a 30 minute mandatory wait period after receiving your shot due to a risk of anaphylaxis at any time during your therapy. Leaving early may lead to termination of your allergy shots.

You may be required to make a clinic appointment for various reasons, including reactions to therapy or missed shots greater than 6 weeks. We require seasonal clinic visits during your build-up phase, and at least annually once you reach your maintenance/therapeutic phase.

Please update the nurses on any medication changes, changes in health history, etc. It is especially important to avoid beta-blocker medications while on allergy shots since they can make it difficult to treat a serious reaction, should one occur.

Effective Date: December 18, 2023

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.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:
Privacy Officer: LAKESHORE ALLERGY, PC – Practice Administrator
Phone Number: (616) 738-4262

Section A: Who Will Follow This Notice?

This Notice describes **Lakeshore Allergy, PC** (hereafter referred to as 'Provider') Privacy Practices and that of:

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations. These workforce members may include:

All departments and units of the Provider.
Any member of a volunteer group.
All employees, staff and other Provider personnel.
Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice.

Section B: 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 you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

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 with respect to medical information about you; and
Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to

know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider.

Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Provider may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the Provider so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.

Healthcare Operations. We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

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

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities. We may use information about you to contact you in an effort to raise money for the Provider and its operations. We may disclose information to a foundation related to the Provider so that the foundation may contact you about raising money for the Provider. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at the Provider. If you do not want the Provider to contact you for fundraising efforts, you must notify us in writing and you will be given the opportunity to ‘Opt-out’ of these communications.

Authorizations Required. We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes uses of your PHI for marketing or sales activities.

Emergencies. We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

Psychotherapy Notes. Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.

Communication Barriers. We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

Provider Directory. We may include certain limited information about you in the Provider directory while you are a patient at the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

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

To Avert a Serious Threat to Health or Safety. We may use and disclose medical 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.

E-mail Use. E-mail will only be used following this Organization’s current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

Organ and Tissue Donation. If you are an organ donor, we may release 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.

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

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally 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 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; and

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.

Health Oversight Activities. We may disclose medical 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.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you 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 to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

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 result of criminal conduct;

about criminal conduct at the Provider; and

in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release 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 patients of the Provider to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

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

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Access, Inspect and Copy. You have the right to timely access to inspect, receive copies of and direct copies be sent to third parties of the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect, receive or direct copies be sent of your medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that 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 or for the Provider. In addition, you must provide a reason that supports your request.

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:

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the medical information kept by or for the Provider;

Is not part of the information which you would be permitted to inspect and copy; or

Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you 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.

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 payment or healthcare operations. You also have the right to request a limit 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. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.

You also have the right to restrict use and disclosure of your medical information about a service or item for which you have paid out of pocket, for payment (i.e. health plans) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

a brief description of the breach, including the date of the breach and the date of its discovery, if known;

a description of the type of Unsecured Protected Health Information involved in the breach;

steps you should take to protect yourself from potential harm resulting from the breach;

a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;

contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

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 work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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. You may obtain a copy of this Notice at our website. **www.lakeshoreallergypc.com**

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

We reserve the right to change this Notice. 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. The Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services; http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Healthcare Arrangement

The Provider, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your healthcare needs.

Revision Date: March 03, 2013, to be compliant with HIPAA Omnibus Privacy Rules. Original Effective Date: April 14, 2003.

At all times, the patient has the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective except to the extent that this Organization has already taken action in reliance upon this Consent. This Organization may refuse to treat the Patient if he/she (or authorized representative) does not sign this Consent form. This Organization has the right to refuse further treatment after the time this Consent is revoked (except to the extent this Organization is required to provide treatment under the law).