Columbia Asthma & Allergy CLINIC

Fishers Landing ◘ Salmon Creek ◘ Longview ◘ Clackamas ◘ Gresham ◘ Fremont ◘ San Leandro ◘ Bellevue ◘ Oakland ◘ Sunnyvale ◘ Redwood City

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please read carefully.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI):
This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future health or condition and related health care services.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

FOR TREATMENT: We will use health information about you to furnish services and supplies to you, in accordance with our policies and procedures.

FOR PAYMENT: We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. In addition, certain information may be released to a collection agency, if necessary, to collect payment from you.

FOR HEALTH CARE OPERATIONS: We may use and disclose information about you for the general operation of our business: Accreditation organizations, auditors or other consultants, for example.
We may disclose protected health information about you in connection with certain public health reporting activities. We may disclose such information to a public health authority authorized to collect or receive PHI for example: State health departments, Center for Disease Control, and the Food and Drug Administration to name a few. We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect, domestic or elder abuse. Additionally we may disclose PHI to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations, to track products, to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

We may disclose PHI in connection with certain health oversight activities of licensing and other agencies. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1)the health care system, 2)governmental benefit programs for which health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, 4)entities subject to civil rights laws for which health information is necessary for determining compliance. We may disclose information in response to a warrant, subpoena, or other order of a court or administrative hearing body, and in connection with certain government investigations and law enforcement activities. If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials. Workers Compensation Programs. We may release your PHI to workers' compensation or similar programs. Avoid Harm. PHI will be disclosed if necessary to prevent a serious threat to the health and safety of you or others. Research Purposes. We may use or disclose certain PHI

about your condition and treatment for research purposes where and Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment. Please note that no medical information or personal health information will be left on a recorder, voice mail or discussed with anyone other than you unless given permission in writing.

Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you. Individuals Involved in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care, but we will obtain your agreement before doing so. This includes people and organizations that are part of your "circle of care"—such as your spouse, your other doctors, or an aide who may be providing services to you. Although we must be able to speak with your other physicians or health care providers, you can let us know if we should not speak with other individuals, such as your spouse or family members. We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization. We will be unable to take back any disclosures already made based upon your original permission.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI:
The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask for restrictions on the uses and disclosures of your PHI beyond those imposed by law. We will consider your request, but we are not required to accept it. The Right to Choose How We Send PHI to You. You have the right to request that you receive communications containing your PHI from us by alternative means or locations, i.e. Email The Right to See and Get Copies of Your PHI. Except under certain circumstances, you have the right to inspect and copy medical and billing records about you. We may charge you a fee for copying and mailing. The Right to Get a List of the Disclosures We Have Made. You have a right to ask for a list of instances when we have used or disclosed your medical information for reasons other than your treatment, payment for services furnished to you, our healthcare operations, or disclosures you give us authorization to make. If you ask for this information from us more than once every twelve months, we may charge you a fee.

IV. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES:
If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your PHI, you may file a complaint with Dr. Sanjeev Jain, owner of Columbia Asthma & Allergy Clinic. Please request the grievance form from the receptionist or the business office manager. On completion of this form it will be given directly to Dr. Jain and the Compliance Committee for their immediate review and resolution. The Compliance Committee consists of the clinic staff. You may also send a written complaint to the Sec. of the Dept of Health and Human Service at 200 Independence Ave, SW, Room 509F, HHH Bldg., Washington, DC 20201. This clinic will not take any retaliatory action against you for filing a complaint about our privacy practices.

If you have any questions about this notice or any complaints about our privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Columbia Asthma & Allergy Clinic, Attention: Compliance Officer, 1406 SE 164th Ave, Suite 250, Vancouver, WA 98683 | (360)-834-6700.

I, _____have received and/or read a copy of Columbia Asthma & Allergy Clinic Notice of Privacy Policies.

_____

Signature Date

You have the right to a copy of this Notice in paper form. You may ask us for a copy at any time.

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How to Prepare for Your First Appointment

1. Please bring your insurance card(s), photo ID and all new patient paperwork. Please ensure all paperwork is filled-out completely *prior* to your arrival. Please check-in at least 15 minutes prior to your scheduled time to allow our Patient Care Coordinators at the front desk to check you into the system.

2. Bring all medication bottles of drugs you are currently taking. This includes any over-the-counter, herbal and as-needed medications. By bringing in the actual prescription bottles, we will be able to accurately record your dose and all other pertinent information we need for your medical chart.

3. Bring a list of any medication and food allergies that you may have and a description of the type of reaction you had to the medication and/or food.

4. Bring your Primacy Care Provider's contact information and your past medical history. If available, please bring in any medical records from previous medical appointments. This information will be very helpful in performing a comprehensive evaluation.

5. Please allow approximately 1.5 hours for your first appointment. If you have any questions regarding any of these instructions, please do not hesitate to call us for clarification.

TESTING FOR ASTHMA: Sometimes we perform lung function testing in which you breathe into a handheld device connected to a computer. This determines whether or not you have asthma. This test also determines how well your asthma is controlled with the current medications you are taking.

New Patient History Questionnaire

Date of Visit:_____ Primary Provider:_____
Patient Name:_____ DOB:_____ Gender:_____

How did you hear about our clinic?

- ❑ Advertisement (please specify): _____
- ❑ Social Media (please specify): _____
- ❑ Friend/ current patient: _____
- ❑ Referring physician: _____
- ❑ Other: _____

Briefly state what symptoms are bringing you here:

_____

_____

Have you ever seen a specialist (allergist, dermatologist, ENT, pulmonologist) for allergy-related problems? ❑ yes ❑ no

If yes, who? _____

Environmental Allergy Symptoms (Check all that apply) If none, check here: ❑

Nose / Sinuses / Throat
- ❑ sneezing
- ❑ itching nose
- ❑ congestion / stuffiness
- ❑ runny nose (❑clear ❑colored)
- ❑ nose bleeds
- ❑ snoring
- ❑ loss of smell
- ❑ nasal polyps
- ❑ history of deviated septum
- ❑ post nasal drip
- ❑ scratchy throat
- ❑ dry throat
- ❑ sore throat
- ❑ constantly clearing throat
- ❑ headache

Eyes
- ❑ itchy
- ❑ watery
- ❑ redness
- ❑ eyelids swollen
- ❑ sensitive to light
- ❑ blurred vision

Ears
- ❑ itching
- ❑ plugging
- ❑ discharge
- ❑ aching/pain
- ❑ hearing loss
- ❑ recurrent ear infections

Previous Allergy Testing/Treatment
- ❑ Allergist evaluation (Date:_____)

Symptoms are aggravated by:
- ❑ tobacco smoke
- ❑ exercise
- ❑ cold air
- ❑ animals
- ❑ workplace or school
- ❑ dusting or vacuuming
- ❑ odors or scents
- ❑ yard work
- ❑ weather change
- ❑ being outdoors
- ❑ aspirin / related medications
- ❑ other: _____

Symptoms first began:
- ❑ childhood at age _____
- ❑ adult at age _____

❑ sinus pressure / pain ❑ frequent sinus infections (# per year_____) ❑ Nasal / Sinus Procedures (circle): surgery, sinus x-ray, sinus CT Date(s):_____	❑ ENT evaluation (Date:_____) ❑ skin testing (Last Date:_____) ❑ blood testing (Last Date:_____) ❑ allergy shots (for ____ years and stopped in _____ (year)	**Symptoms occur in:** ❑ spring ❑ summer ❑ fall ❑ winter **Symptoms interfere with:** ❑ sleep ❑ work/school ❑ recreation

Current Medications (Prescription, Over-the-Counter, Vitamins, Supplements, etc.)

Medication Name:	Strength / Dose / Frequency:	Start Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Medications Tried:_____

Medication / Drug Allergies If No Drug Allergies, check here: ❑

Drug/Medication Name:	Description of Reaction:	Reaction Date:
_____	_____	_____
_____	_____	_____

Asthma / Respiratory Problems (Check all that apply) If none, check here: ❑

❑ Asthma diagnosed in year _____ ❑ Asthma NOT diagnosed, but: ❑ frequent bronchitis/croup ❑ respiratory troubles as a child ❑ inhalers like albuterol help ❑ steroid medicine helps	**Previous Testing/Treatment** ❑ Pulmonologist evaluation Last Date:_____ ❑ Pulmonary function testing Date(s):_____ ❑ Chest x-ray Date(s):_____	**Symptoms are aggravated by:** ❑ tobacco smoke ❑ exercise ❑ cold air ❑ animals ❑ workplace or school ❑ dusting or vacuuming

❑ COPD/emphysema diagnosis (year_____)
❑ cough
❑dry
❑ wet / mucus
❑clear, ❑yellow/green, ❑bloody
❑ chest tightness
❑ chest pain
❑ shortness of breath
❑ wheezing
❑ lips and/or fingernails turn blue

Symptoms first began:
❑ childhood at age _____
❑ adult at age _____

❑ ER visits
- How many?_____
- Last visit:_____

❑ Hospitalized _____ times
Last hospitalization:_____

❑ Oral steroids: ____ courses/year
❑ Albuterol use:
❑ ____ times per week
❑ ____ times per month

❑ odors or scents
❑ yard work
❑ weather change
❑ being outdoors
❑ aspirin / related medications
❑ other: _____

Symptoms occur in:
❑ spring ❑ summer
❑ fall ❑ winter

Symptoms interfere with:
❑ sleep ❑ work/school ❑ recreation

Skin Problems (Check all that apply) If none, check here: ❑

❑ itching
❑ dry, scaly skin
❑ eczema
❑ welts, hives
❑ rash
❑ skin swelling
❑ recurrent skin infections

Location of skin problems:
_____

Symptoms first began:
❑ childhood at age _____
❑ adult at age _____

Previous Testing/Treatment
❑ Dermatologist evaluation
Last Date:_____
❑ medications (see medication list)
❑ moisturizers
❑ other:_____

Symptoms are made worse by:
_____
_____
_____

Symptoms interfere with:
❑ sleep ❑ work/school
❑ recreation

Food Allergies If No Food Allergies, check here: ❑

Previous food allergy testing? ❑no ❑yes (If yes, ❑skin test ❑blood test Date(s):_____)

Food(s) Causing Reaction:	Description of Reaction:	Reaction Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____

Latex, Insect Stings, Chemicals, and Other Allergic Reactions		If No Other Allergies, check here: ❑
Item Causing Reaction:	Description of Reaction:	Reaction Date:
_____	_____	_____
_____	_____	_____

Other Past Medical History

Immunizations: ❑ up to date ❑ not up to date

Have you received: 1)Flu vaccine in past year: ❑ yes ❑ no 2)Pneumonia vaccine: ❑ yes in _____(year) ❑ no

Surgeries / Hospitalizations (details and date):_____

Other Medical Conditions: ❑ None

❑ Diabetes	❑ Thyroid Disease
❑ Seizures	❑ Kidney Disease
❑ Heart Disease	❑ Liver Disease
❑ High Blood Pressure	❑ Other Lung Diseases_____
❑ GERD	❑ Other_____

Family History If Unknown, check here: ❑

	Father	Mother	Brother(s)	Sister(s)	Child(ren)	Grandparent(s)
Hayfever / Allergies: Sinus Trouble:	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Asthma: Frequent Bronchitis:	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Eczema: Hives:	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Migraine Headaches: Thyroid Disease:	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Food Allergies: Other:_____	❑	❑	❑	❑	❑	❑

	❑	❑	❑	❑	❑	❑

Autommune Disease (in any relatives):_____

Social History

Occupation:_____
Recent Travel History:_____
Marital Status: ❑Single ❑Married ❑Divorced/Sep. ❑Widowed
Exercise:_____
Hobbies:_____
Special Diet?:_____

Current smoker? ❑no ❑yes, ___ packs per day
Past smoker? ❑no ❑yes, ___ packs per day for ___ years. Quit in _____.
Alcohol Use: ❑None ❑1-5 drinks per week ❑More than 5 drinks per week
Recreational Drug Use (confidential): ❑yes ❑no

Environmental History

Primary residence: ❑House ❑Apartment/Condo/Townhouse ❑Mobile Home **Location**: ❑city/suburban ❑rural
Residence is ____ years old and have lived there for ___ years.
Previously lived in (city/state/country):_____

Does your home have a basement? ❑no ❑yes
(if yes, ❑finished ❑unfinished ❑dry ❑damp ❑musty)
History of water damage in home? ❑no ❑yes
Is there mold visible in the home? ❑no ❑yes
Smokers in the home? ❑no ❑yes

Pets: ___dog(s) ___cat(s) Other:_____
❑indoor ❑outdoor ❑allowed in bedroom

Heating: ❑central ❑electric ❑gas ❑radiator ❑wood fireplace ❑gas fireplace
Air Conditioning: ❑central ❑in-window ❑fans
Filter System: ❑yes ❑no
Humidifier: ❑yes ❑no
Flooring:
In main areas: ❑carpet ❑laminate ❑hardwood
In bedroom: ❑carpet ❑laminate ❑hardwood
Bed: ❑mattress/boxspring ❑latex ❑foam ❑waterbed ❑other_____
(Allergy encasement? ❑yes ❑no)
Pillows: ❑feather ❑non-feather
(Allergy encasements? ❑yes ❑no)

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PATIENT REGISTRATION

Today's Date:_____

Patient's Name: _____ DOB: _____ Sex:_____

Mailing Address: _____

City/State: _____ Zip code_____ SS#: _____

Email: _____ Phone#: _____

Occupation: _____Work Phone#: _____

Responsible Party:_____DOB: _____ Relationship: _____

Mailing Address: _____

City/State: _____ Zip code_____ SS#: _____

Email: _____ Phone#: _____

Occupation: _____Work Phone#: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Ins. Address: _____ Ins. Address: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

ID#: _____ ID#: _____

Group#: _____ Group#: _____

Employer: _____ Employer: _____

Effective Date: _____ Effective Date: _____

Emergency Contact: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Columbia Asthma & Allergy Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ **Date:** _____

Sanjeev Jain, MD, PhD • Stephen Fritz, MD • Michael Noonan, MD • Jon Welch, MD
Paul Cheng, MD, PhD • Renu Gandhe, MD • Umesh Sab, MD

REFERRING PHYSICIAN INFORMATION FORM

Were you referred to CAAC by another provider? □ Yes □ No

Referring Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

As a courtesy to other providers working on your medical team and to assist with continuity of care, CAAC is happy to send a copy of your medical records to any physician you specify. Please list them below:

Primary Care Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

Type of Physician: _____

By signing this document, I authorize CAAC and its providers to release my medical records to the above named physicians. I may revoke this authorization at any time in writing.

Patient/Guardian Signature:_____ **Date:** _____

www.columbiaallergy.com