

**Allergy & Asthma Center**  
**Anita N. Wasan, FAAAAI, FAAAAI**  
6824 Elm Street, Suite 120, McLean, VA 22101  
Tel: 703-992-7065, [www.novaallergy.com](http://www.novaallergy.com)

**PRIVACY AND CONFIDENTIALITY RELEASE OF INFORMATION**  
**HIPAA Compliance Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. This notice describes your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in our electronic medical record system, Practice Fusion. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

1. I give permission for Dr. Anita Wasan or staff to discuss my treatment with my spouse/partner/family members about my presence in the office. Such discussion may include my diagnosis and treatment.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

Name(s) of person (s) I designate:

\_\_\_\_\_

2) I give permission for Dr. Anita Wasan or staff to discuss my appointments, my treatment, or test results I have had with the above person (s) I have designated when I may/may not be present.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

3) I give permission for Dr. Anita Wasan or staff (and the Electronic Medical Record) to leave messages/emails/texts for me regarding appointments and/or test results. I give permission to leave voice mails on the answering machine/voice mail on the telephone number below which I designate.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

Telephone number to leave  
message: \_\_\_\_\_

I can revoke this authorization at any time in writing.

Patient Signature: \_\_\_\_\_

### **Assignment and Release**

I, the undersigned, have insurance coverage with \_\_\_\_\_ (name of insurance company) and assign benefits, if any, directly to the Allergy and Asthma Center, otherwise payable to the insured for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If any amount due remains unpaid after a bill is rendered, I agree to pay all costs of collection, including reasonable attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

### **Release of Medical Records to our Practice from other Health Care Providers**

I, undersigned, authorize the Allergy and Asthma Center, to obtain any medical records that may pertain to my medical care. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released and thereby release the Allergy and Asthma Center, and staff, from all legal responsibility that may arise from the authorized.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

### **Notice of Privacy Practices**

I have received a copy of the Allergy and Asthma Center's Notice of Privacy Practice. If you would like a copy please request it at our front desk.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

### **Consent for Purposes of Treatment, Payment and Healthcare Operation (Reproduced from AMA/ACP model)**

I consent to the use or disclosure of my protected health information by the Allergy and Asthma Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operation of the Allergy and Asthma Center. I have the right to revoke this consent, in writing, at any time, except to the extent that Anita N. Wasan, MD or the Allergy and Asthma Center taken action, relying on this consent. "Protected health information" is the health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information involves my past, present or future physical or mental health or condition and identifies me (or on a reasonable basis, identifies me).

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

## **PATIENT FINANCIAL POLICY**

**This Practice has contracts with most insurance companies. Effective in June 2023, the practice also participates in Medicare.** If you obtain medical services from the Allergy and Asthma Center, you / or your beneficiary / legal representative accepts full responsibility for payment of the physician charges / services furnished by the physician after we receive the Explanation of Benefits from your insurance company. It is the patient's responsibility to check their benefits with their insurance company. We do not submit to secondary insurance companies. It is ultimately the responsibility of the patient (or legal guardian) to determine coverage and benefits by their insurance carrier.

We will do our best to check benefits prior to any procedures done at our office, but this is not a guarantee of coverage. Therefore, if we determine that you may have a high deductible, we will charge you \$100-200 for skin test, serum mixing, and/ or patch test procedures done in the office at the time of your appt. This amount will be applied to your deductible and patient statement.

**It is the responsibility of the patient to make sure they have secured any referrals (for insurance purposes) that are required for their office visit; this referral will need to be provided at the time of the appointment.** Patients / guardians are responsible for any outstanding balances that may arise out of not having the appropriate referral.

If we have a contract with your plan, we will file a claim with your insurance company upon receipt of an updated insurance card. You are responsible for all charges that are not covered by your insurance company (i.e. deductibles, copays for a specialist visit, coinsurance). These amounts will be due within one month of your visit. A bill will be sent out to your home once we get the EOB (explanation of benefits) from your insurance company.

Your copay for a **specialist** office visit is due at the time of your office visit before you are seen by the provider.

We accept cash, checks, Visa, and MasterCard. There is a **\$75.00** charge for returned or cancelled checks.

If you fail to pay your balance to the Allergy and Asthma Center and it becomes necessary to take action to collect on your account, you agree to pay for all costs in the collection of your balance including any collection agency and / or attorney fees.

**The Allergy and Asthma Center has a 24 hour business-day cancellation policy. If you have an appointment on Monday, we will need the cancellation confirmed by the end of our business day on the previous Friday. There is a \$ 50.00 fee for missed patient appointments and a \$100.00 fee any missed food, drug, or environmental challenge appointments.**

There is a \$50.00 medical record fee for copying, mailing and/or faxing any medical records and a \$25.00 fee for filling out any school forms per patient. There is a \$50.00 fee for taking out any allergy shot vials and records to an outside facility per year per patient. Please allow 48-72 hours (business days) for the forms to be completed by the provider. All form fees need to be collected prior to sending the forms to the appropriate location. We do not mail allergy serum vials. Any delivery of the vials is the responsibility of the patient and/or guardian.

The medical record release form needs to be completed by the patient or legal guardian prior to sending any necessary medical records, and the fee will need to be collected prior to the records being sent.

I have read and understand the financial policy of the Allergy and Asthma Center and agree to comply with it.  
Signature of Patient / Responsible Party:

\_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

### **ELECTRONIC MEDICAL RECORD SYSTEM**

The Allergy and Asthma Center uses an electronic medical record system with a patient portal through HIPAA compliant Practice Fusion. Once making your appointment, the patient should receive an email with a portal link to create an account. The patient should also receive an appointment confirmation with a link to complete part of the patient intake forms. We do not accept forms via email or by cellular device. If you need to send us any forms or images, please create a portal account and send the appropriate forms or images via the secure portal. The portal allows the patient to communicate non-urgent messages to the provider and to also view lab results. Appointments can be made through our website, [www.novaallergy.com](http://www.novaallergy.com).

### **MEDICAL EMERGENCIES:**

In case of medical emergencies, we do not recommend calling us and leaving a voice mail or messaging us through the portal. If the patient is having an emergency, please call 911 and go to your nearest emergency room or urgent care center. Please inform us if the patient did have a medical emergency so that we can do our best to arrange follow up care.

## **CREDIT CARD POLICY**

At the Allergy and Asthma Center, we require keeping your credit card or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover (or for self-pay patients), but for which you are liable.

For the balances that you may owe to the Allergy and Asthma Center, our billing service, Physicians Billing Services, Burke, VA, will send out two statements (separated by 30 days) to see if you can pay directly before running your credit card. If your credit card is not on file, then we will be sending you to the collections services if we do not receive payment at the end of the billing cycle for the two statements.

Your credit card information is kept confidential and secure, and payments to your card are processed only after two billing statements have been sent to you (based after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account). I authorize the Allergy and Asthma Center to charge my balance (my financial responsibility) to the following credit or debit card:

Credit Card Number:

\_\_\_\_\_

Type of Card:            AmEx.            Visa            MasterCard            Discover

Expiration Date: \_\_\_\_\_

CVV (three-digit code [or four-digit for Amex]): \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Billing Address including zip code:

\_\_\_\_\_

\_\_\_\_\_

I, the undersigned, authorize and request the Allergy and Asthma Center, to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by the Allergy and Asthma Center.

This authorization will remain in effect until I cancel this authorization by giving a 60 day notification to the Allergy and Asthma Center in writing (and the account must be in good standing).

Patient Name (or Guardian if Patient is a Minor):

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_