Eugene W. Tsai, MD
1360 W. Sixth Street, Suite 310, San Pedro, CA 90732
3801 Katella Avenue, Suite 222, Los Alamitos, CA 90720
Phone (310) 241 – 0822 or (562) 594-8831
Website: www.sanpedroallergy.com or www.losalamitosallergy.com

LIST OF FORMS

Please also send to the office a copy of your identification card and your medical insurance card. If all of these forms are not received before your appointment with Dr. Tsai, you may need to be rescheduled.

Thank you.

Introduction Letter

Dear Patient or Parent,

We look forward to meeting you at your first visit. For new patients, we like to spend the appropriate amount of time needed to understand your problems with allergy, asthma, or immunology and to explain options for diagnosis and treatment. Your first visit with us will usually last 30 to 60 minutes depending on the complexity of your case. So, please be sure to allow enough time in your schedule for this consultation. If you need to reschedule your appointment with us, as a courtesy, please notify our office 24 hours in advance of your scheduled appointment.

We perform all of our allergy skin testing in our Los Alamitos office. We schedule allergy skin testing during a follow up visit AFTER a patient's first visit with us if it is determined that allergy testing is needed. We prefer to spend the time during the first visit to carefully assess your condition and discuss options for further diagnosis and treatment. Allergy shots are given in both our Los Alamitos and San Pedro offices.

Our office requires a credit card on file for patients with insurances that require a co-payment, co-insurance, or a deductible. It is not uncommon for medical offices to require a credit card to secure a new patient appointment. This is typically done to protect the medical practice from no-shows or last-minute cancellations, which can be costly for the practice and prevent other patients from receiving timely care. We want you to know that our practice follows certain guidelines when collecting credit card information from patients. These guidelines include obtaining explicit consent from patients before charging their credit card for any services or fees. We use a secure and encrypted system to collect and store patient credit card information. If you have any concerns about providing your credit card information to our medical office, please feel free to call with any questions before scheduling your appointment.

For more information about our office, you can visit us at www.losalamitosallergy.com or www.sanpedroallergy.com. Thank you for taking the time to fill out the following forms.

Sincerely,

Eugene W. Tsai, MD and Dennis Jerome, MD

Allergy & Asthma
SPECIALISTS OF LOS ALAMITOS

New Patient Information Record

Patient_____

First Name Middle Name Last Name

Marital Status: □Single □Married □Widowed □Other_____

Gender: □ Male □Female Age_____

Address_____

City_____ Zip Code_____ Date of Birth_____

Phone Number ( )_____Cell ( )_____

Email_____

INSURANCE INFORMATION

Name on Insurance Card:_____

First Name Middle Name Last Name

Relationship to Patient: □Self □Parent □Spouse □Other_____

Date of Birth:_____

Referred by:_____

(Name of the physician or referring person)

Friend or Relative to Contact in Case of Emergency: _____

Relationship to Patient: _____

Phone Number: ( ) _____Cell ( )_____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize Eugene W. Tsai, MD, APMC to disclose when requested by the above named insurance carrier of its representatives any and all information with respect to any illness(es) of injury(ies), medical history, or treatment and copies of all medical records. A photographic copy of this authorization shall be considered as effective and valid as the original.

I hereby authorize payment directly to Eugene W. Tsai, MD, APMC of the surgical and /or medical benefit if any, otherwise payable to me for professional services rendered to me. I understand that I am financially responsible for the charges not covered by this authorization. I further agree in the event of non-payment to bear the cost of reasonable legal fees should this be required.

Date_____ Signature_____

Environmental, Social, and Family History

Environmental Survey

What city or cities does the patient live in? _____
Patient lives in a (house, condo, apartment, or other _____). Please circle one.
How old is your home? (less than 10 years old, between 10 to 25 years old, older than 25 years old). Please circle one. How many years has the patient been living there?_____
What type of flooring do you have (hardwood, laminate, carpet, rugs, tile). Please circle all that apply. For patients with carpeting, how old are your carpets?_____
What type of pets do you have? _____
Does patient smoke? Yes No If yes, how many packs per day _____
Does anyone in the family smoke? Yes No Has patient ever smoked? Yes No
Does patient have their own bedroom? Yes No If no, how many people share? ____

Social History (fill out for patients older than 6 years of age)

What does patient do for a living or what grade in school? _____
What does patient do in their spare time or hobbies? _____
What does patient do for exercise ?_____
Any recent foreign travel in the past 12 months? _____

Social History (fill out for patients less than 5 years of age)

Does your child attend daycare? Yes No (please circle) Do any of your other children attend daycare? Yes No (please circle) What type of formula did your child use in their first year of life? _____At what age did you introduce solid foods to your child? _____At what age did you introduce cow's milk to your child?_____
List any foods that your child avoids because of allergies?_____

Family History

Does anyone in your family have nasal allergies, asthma, or eczema? Yes No
What type of medical problems run in the family?_____

Drug Allergy

Do you have any allergies to medications? Yes No If Yes, which ones _____
_____

HIPPA Patient Consent Form

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to receive our notice before signing the consent. The terms of our notice may change. If we change notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclose for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for your treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

1) Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2) The practice has a Notice of Privacy Practice and that the patient has the opportunity to review this notice.
3) The Practice reserves the right to change the notice of privacy practices.
4) The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.
6) The practice may condition receipt of treatment upon the execution of this consent.

This Consent was signed by:	Signing of Consent was witnessed by:
_____	_____
Printed Named-Patient or Representatives	Physician
_____	_____
Patient or Representatives Signature	Signature of Physician
_____	_____
Date	Date

Patient Financial Responsibility

We would like to take this opportunity to welcome you to our practice and tell you that we are grateful that you have chosen our practice for your allergy care. For your information and convenience, we would like to inform you of our billing policies. Our policies have been made to ensure that we are in full compliance with insurance companies/third party payers, guidelines established by Medicare, and federal rules and regulations.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. In other words, you agree to have your insurance company pay the doctor directly. Not all insurance companies/third party payers pay for all services. Each policy has its own particular stipulations regarding covered services and amount of coverage. All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company only AFTER a claim is received.

Copayments and Deductibles

Co-payments and/or co-insurance are due at the time of your visit. We are prohibited by law to waive any or all copayment or deductibles; therefore we must collect all co-payments and deductibles designated by your insurance carrier. Current fraud and abuse laws governing federal, state, and third party payer contracts mandate that we cannot grant financial hardship without documented proof.

So, what is a medical deductible? A medical deductible is the amount set by your insurance company that must be met before your insurance company will begin paying for medical services (office visits, allergy testing, shots, or labs). For example, if you have a medical deductible of $2,000 dollars per year, you will be required to pay for services specified by your insurance up to $2,000 dollars. Only after you meet your deductible (spent $2,000 dollars from the above example), will your medical insurance company begin paying for additional medical services.

It is very important to understand the specifics about your medical coverage. If you have any questions, you can call the customer service number on the back of your insurance card. A credit card payment of $150 dollars is required for all patients with a deductible for a new patient visit. An additional credit card payment may be required subsequently before undergoing allergy skin testing, pulmonary function testing, or immunotherapy ("allergy shots").

Medical Insurance Information

It is your responsibility to give our office current and up to date information. This includes correct names, address, telephone number, and other demographic information.

It is your responsibility to provide us with all current insurance information. This includes informing us of all insurance companies that provide you coverage (if more than one). Changes in insurance coverage must be reported to our staff promptly. In the event the office is not informed, you will be responsible for any charges denied.

It is your responsibility to know what medical services are covered and are not covered by your insurance company. If you are not sure if you have a deductible, you should contact your insurance company. As a courtesy we do check your insurance benefits. However, we cannot be held responsible for any inaccuracies or discrepancies that your insurance company may provide to us.

It is your responsibility to provide this office with referrals from your primary care physician if needed by your insurance company (HMO). Authorizations for medical services from your insurance company/doctor do not guarantee full payment for the services. You will be still be responsible for any charges denied.

It is your responsibility to know your insurance plan's policies and guidelines. Every insurance company is different. You should know if your insurance company has a preferred lab or hospital which we are required to use in order for your services to be covered.

It is your responsibility to contact your insurance company to verify that any physician you see in this practice is a participating physician with your insurance company and with your specific plan. For example, there are some insurance companies that will pay for all medical services provided by Doctor A but only pay partially for Doctor B despite both Doctor A and Doctor B being "in network".

It is your responsibility to verify there are sufficient funds on all check payments made to our office. There will be fee of thirty-five dollars charged for all returned checks.

Divorced/Separated Parents of Minor Patients

The parent who consents to the treatment of a minor child is responsible for payment of services rendered regardless of any custody, separation, or divorce arrangements. Our office will not be involved with separation or divorce disputes.

Medical Records

For copies of medical records, pursuant to the California Health & Safety Code, Division 106, Chapter 1, §123110, the medical provider may charge 25¢ per page plus the costs of labor (25.00 dollars), supplies, and postage, if applicable. Turnaround time for medical records are usually within 7 business days but may be longer depending on time of the year.

Acknowledgment of Patient Financial Responsibility

The patient or patient's legal representative hereby acknowledges that he/she is eligible for health insurance benefits and coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the physician accordingly. The undersigned understands that all bills are payable upon presentation and that she/he, not the insurance company, is responsible for the payment of the services. This office will file and collect from insurance when insurance benefits are present. The undersigned, having read and understood the agreement, accepts this financial responsibility agreement.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full. I authorize payment to be made on my behalf to Eugene W. Tsai MD APMC for any services provided to me by Eugene Tsai, MD. I also authorize Eugene Tsai, MD APMC to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered on above patient.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

_____

Witness

Forms Completion Policy

The only documentation regarding your health or illness required by law (and included in the office visit charge) is an office visit note written by the physician.

Completing paperwork for schools, camps, the Family Medical Leave Act (FMLA) claims, long-term care, life insurance, forms from the Department of Veterans' Affairs, disability claims, or other purposes goes beyond routine medical care. Since these forms require an attending physician signature, Dr. Tsai would be personally responsible for the accuracy of the information provided. Incomplete or inaccurate information may have far reaching consequences for your case. Dr. Tsai does not have the experience or expertise to fill out most of these forms to best benefit your case. Filling out these forms requires a history of considerable amount of time spent with the patient and careful consideration of all your medical conditions which would in most cases would be best served by your primary care doctor. Our practice focuses on the specialty of allergy, asthma, and immunology, while your primary care doctor has a more comprehensive knowledge of your overall health and condition. Therefore, it is our office policy to refer you back to your primary care physician to fill out the forms mentioned above.

For completing forms related to the care of conditions specific for allergy, asthma, and immunology such as school food allergy and asthma action plans, anaphylaxis treatment plans, and forms related to rare immunological diseases (ie Agammaglobulinemia, Hyper IgE Syndrome, B-cell lymphopenia), you will be asked to make a separate appointment and we will fill out the form as part of the office visit without extra charge.

Turnaround time for form completion may be up to 7 business days. Patients and parents should realize that at certain times of the year we may receive many health forms requests in one week and that each of these forms has to be carefully reviewed by Dr. Tsai before it is released. During those times, completion of forms may be longer than 7 business days. Patients and parents are strongly advised not to wait until the last moment.

Forms will be held at our office for patients and/or parents to pick up. Because of Health Insurance Portability and Accountability Act (HIPAA) regulations, forms will not be emailed. If you would like a form to be mailed to the home address on file, please provide us with a self-addressed stamped envelope.

By signing below, I, _____ (patient or guardian name) acknowledge reading the above policies about forms completion for the office of Eugene W. Tsai, MD.

_____ _____

Patient Name (please print) Date

.

_____

Signature

Medical Staff Code of Conduct

To encourage the highest standards of safety and quality, the staff at Eugene W. Tsai, MD, APMC, has adopted this code of conduct to promote a high standard of professional behavior, ethics and integrity. By this, we aim to provide the highest levels of patient care, trust, integrity, honesty, and ethical conduct.

We are committed to act with the competence, skill, and integrity expected of our profession. We behave with dignity and courtesy toward our patients, clients, coworkers, learners, and others in business-related activities. We are honest, fair, reasonable, and objective in our professional relationships.

As healthcare providers, we have an ethical responsibility to make our patients feel secure in their care and to treat our patients respectfully and with dignity. In addition to an ethical responsibility, we have a legal responsibility to comply with all applicable laws and regulations related to patients' rights. We must also comply with local, state, and federal policies regarding informed consent, confidentiality, advance directives, discharge planning, and patient participation in their respective medical care plans.

As healthcare providers, we dedicate ourselves to providing you and your family with a high quality of care. Quality of care is a promise we strive deliver every day in every aspect of our work.

Allergy & Asthma
SPECIALISTS OF LOS ALAMITOS

Code of Conduct for Patients

To provide a safe and healthy environment for staff, visitors, patients and their families, the staff at Eugene W. Tsai, MD APMC expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or our unhappy with the service received in our office, please contact our manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
- Questions about your billing can be addressed to our office manager.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Adults are expected to supervise their children.

The following behaviors are prohibited:

- Possessing firearms or any weapon
- Patients who are under or perceived to be under the influence of alcohol or any other substance will not be treated at that time and can be grounds for dismissal
- Intimidating or harassing staff or other patients
- Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication
- Physically assaulting or threatening to inflict bodily harm
- Making verbal threats to harm another individual or destroy property
- Damaging business equipment or property
- Making menacing or derogatory gestures
- Making racial or cultural slurs or other derogatory remarks regarding creed, religion, color, gender identity, national or ethnic origin, sexual preference, or disability.

By signing below, I acknowledge reading the above patient code of conduct and understand that failure to comply may result in being required to find another physician.

_____ _____

Signature of Patient /Responsible Party Date

Prescription Medication Refill Policy

Eugene W. Tsai, MD, APMC participates with electronic prescribing directly to your mail order and local pharmacies. Our goal is to assist our patients with prescription requests in an efficient and timely manner. Due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

1) It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

2) Medication refills will only be addressed during regular office hours (Monday – Friday (8:00am – 5:00pm). Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.

3) Prescription refills require close monitoring by your provider to ensure its safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow up appointment. We prefer you request any refills of your medications at the beginning of your office visit.

4) Patients requesting new medications or antibiotics must be seen for an appointment. They are not prescribed over the phone because it generally requires an office visit.

5) Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

6) Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

7) It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. Refills will not be provided to patients who have not had an office visit for over 12 months.

8) We reserve the right to charge an administrative fee for if there are multiple requests for prescriptions requested outside of a visit.

_____ _____

Signature of Patient /Responsible Party Date