William N. Sokol, M.D.
Allergy, Asthma and Clinical Immunology

It is customary to pay for service rendered: therefore, all co-pays, deductibles or percentages are due at the time of service. This information is confidential.
We appreciate your cooperation in completing this form thoroughly.
Please print clearly.

*Patient Name*_____*D.O.B.*_____*Sex (M)(F)*

*Address*_____*Marital Status (S) (M) (W) (D)*

*City*_____*State*_____*Zip*_____*Phone ( )*_____-_____

*Driver's License*_____*Social Security #* _____

*Email:*_____

*Patient's Employer*_____*Occupation* _____

*Emergency Contact*_____*Phone ( )*_____-_____*Relation*_____

Referred By _____

INSURANCE INFORMATION

*Subscriber Name*_____*Subscriber D.O. B* _____

Insurance Name: _____ *Policy ID #:* _____ *Group #* _____

*It is your **RESPONSIBILITY** to be aware of your insurance coverage, policy provisions, exclusions, and limitations as well as authorization requirements. This information is furnished by your insurance carrier.*

We attempt to verify that your coverage is valid at the time of your visit.

If responsible party is other than patient, please complete this section thoroughly.

*Primary Party*_____*Relationship to patient*_____

*Address (if different than above)*_____*Phone ( )*_____- _____

I authorize and consent to examination and treatment as deemed necessary to the above-named patient by William N. Sokol, M.D. and staff. I authorize the release of medical information necessary to process this claim. I authorize the payment of medical and/ or Surgical Benefits to physicians or supplier. I acknowledge that I am responsible for payment of charges incurred (including co-pays, deductibles and percentages owed).

*Signature*_____*Date*_____/_____/_____

SUMMARY OF FINANCIAL RESPONSIBILITY

William N. Sokol, M.D.

Loula A. Amin, M.D.

- The **INITIAL HISTORY/PHYSICAL** is $125.00 to $230.00
- **SKIN TESTING**: the series of **SCRATCH TESTS** consist of approximately 30 per visits based on Insurances, for a charge of $10.00 each. The series of **INTRADERMAL TEST** a charge of $15.00 each. (Extensive testing may be required)

- **SUMMARY CONSULTATION**: You will be scheduled for a summary with Dr. Sokol so that he may review all laboratory and skin testing results with you. The charge for the **SUMMARY CONSULTTION** is $150.00
- **ANTIGEN PREPARATION**: At this time of your summary consultation, a commended treatment will be decided upon. If immunotherapy (allergy injections) is indicated, the **ANTIGEN PREPARATION** fee is $200.00 per vial. You will receive a complete serum specifically prepared for you based on your allergy testing results. The set will last approximately 12 months, depending upon treatment plan.
- **ADDITIONAL CHARGES:**

BRONCHOSPASM EVAL. TREATMENTS	$135
PULMONARY FUNCTION STUDY	$80
PATCH SKIN TESTING	$20/ item
STINGING INSECT TESTING	$443 (evaluation)
ECHOSINE	$140

- **Routine charges:**

OFFICE VISITS	$70, $90, $117, $150
IMMUNOTHERAPY INJECTIONS	$21, $30, $45
THERAPUTIC INJECTIONS (celestone, dexamethasone)	$50

PAYMENTS REQUIRED: For **INSURANCE** accounts: **1) deductible 2) "patient responsibility" 3) and co-payments are due at the time services are rendered**. **For CASH accounts:** the total amount is due at the time of the services rendered.

INSURANCE BILLING: Your insurance company will be billed daily for all office visits and immunotherapy injections.

MONTHLY STATEMENTS: You will receive a monthly statement reflecting the amount owed. If you have any questions regarding your account, please do not hesitate to contact the office.

I HAVE READ THE ABOVE AND CLEARLY UNDERSTAND MY FINANCIAL OBLIGATIONS:

_____ _____/_____/_____

Patient or Legal Guardian's Signature Date

FINANCIAL POLICIES AND PROCEDURES

Dear patient,

In our allergy practice, we believe that all patients deserve the best medical care that can be provided. For us to provide the highest quality medical care, we must ensure that we are able to meet the expenses necessary to operate our practice. To ensure that these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

PAYMENT AT TIME-OF-SERVICE FEES AND COLLECTIONS

Your insurance policy is a contact between you and your insurance company. As a courtesy, we will file your insurance claims for you for all office visits and services. However, we will not become involved in disputes between you and your insurance carrier. This includes but is not limited to, deductibles, copayments, noncovered charges, and "usual and customary" charges. If insurance carrier does not provide payment within 60 days, you will be responsible for payment. You are ultimately responsible for the timely payment of your account. We require that you pay any portion not covered by your insurance due to the deductibles or copayments on the day of service at checkout, as this is a requirement of our contract with your insurer. If this information is not provided, or you are unable to provide accurate information, you will be required to pay any charges in full at the time of service. If you are unable to pay your copayments at checkout a payment needs to be issued within 48 hours.

It is your responsibility to provide us with your current insurance information every visit so that we may bill your insurance company in a timely manner. If a claim is rejected due to an expired policy, you will be held liable for the outstanding balance. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. Due to the wide variety of insurance plans, even within one insurer, it is impossible for us to know what is covered under your plan. Please inform yourself as to your coverage so that office visits, injections, skin testing, and laboratory procedures can be charged and arranged to best suit your needs.

Any account that is 30 days past due will become delinquent and placed with our collection agency, a 25% collection charge will be added to your balance for which you are responsible.

If you are seen in our office by a nurse or medical assistant for medical services such as venipunctures, blood pressure checks, peak flow checks, rapid strep screening, or pulmonary function testing, you will be charged a limited office visit and applicable copays will be collected.

BALANCES DUE AFTER INSURANCE PAYMENT

If there is a remaining balance due after your insurance carrier pays, you have 15 days to make a payment in full on the statement. Payment arrangements can be made for special circumstances by contacting out Billing Department within 15 days of the receipt of the statement. It is your responsibility to contact our office to make special arrangements.

OUTSTANDING BALANCES

We urge to keep your account current to avoid any misunderstandings with our office. All account balances past 30 days or more will be submitted to out collection process and possibly to the district court for collection purposes. If your account is handled by the district court, you will be responsible for all court fees associated with collections on your account. At that point, the account is out of our hands.

PAYMENT ARRAGEMENTS

Under special circumstances, payment arrangements may be made. These arrangements are made with the Billing Department or front desk receptionist. Our office can set this up for you as a courtesy. If you are on a payment plan, a monthly statement will not be sent to you. It is your responsibility to know your payment sue date, which will be determined at the time your payment arrangement is set up. After one missed payment, the account will be submitted to our collection agency.

PAYMENT OPTIONS

Our office accepts Visa, Master cards, checks and cash. We will also offer the ability to keep a credit card authorization on file at our office. Any time a copay or balance is due, we can charge the fee to your credit card, wish to pay by cash, please ask for a receipt so that you will have a record of your payment.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier but do not have a secondary insurance, you are responsible for the deductible and copays at the time of service. Payment plans may be set up for special circumstances.

SECONDARY INSURANCE

As a courtesy to you, we will file your claim if we have valid information on file.

NONCONTRACTED INSURANCE (OUT OF NETWORK)

If you have an insurance plan with which we do not participate, you may have out-of-network benefits. These benefits typically have higher copays, Coinsurance, and/or deductibles out-of-pocket costs. You will be considered a self-pay uninsured patient if you do NOT have in-network benefits.

UNINSURED/SELF-PAY

We offer a discount to all our self- pay patients. Payment in full is expected at your first visit. All other ancillary treatment and future care will be reviewed with you to decide for payment. We reserve the right to offer courtesy services in certain circumstances.

NONPAYMENT

If any account becomes delinquent for more than 30 days, we reserve the right to process collection proceeding, which could entail a collection agency or district court. If any account is placed in nonpayment status, the patient will be responsible for all cost of collection or any legal proceedings. TIMELY PAYMENT WILL PREVENT CONSEQUECES TO YOUR CREDIT RATING.

BILLING PROCEDURED

You will receive one statement with your remainder balance once a reply is received from your insurance company. This balance is due within 30 days after which collection procedures may begin.

MISSED APPOINTMENTS/NO SHOWS

We understand that you may not be able to keep all your scheduled appointments. Please understand that missed appointments have a detrimental effect on our practice; not only financially, but also affect our ability to serve other patients in need of medical care. We understand there may be circumstances that may require you to cancel your appointment. If you must cancel your appointment, please do so at least 24 hours in advance or before. We reserve the right to charge $50 for any missed appointment or any appointment that was not rescheduled or cancelled the day prior to your scheduled visit. This will be your responsibility.

RETURNED CHECKS

Returned checks are subject to a $50 service charge. If more than one returned check is received, we reserve the right to refuse further checks from you and request that all payments be received in cash, money order, cashier's check, or credit cards.

REFFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, we will be unable to treat you and you may be sent back to your primary care physician to obtain authorization prior to being treated, or full by payment will be expected at the time of service. Please remember it is your responsibility to make sure we are on your plan's provider listing. We appreciate your understanding of the ever-changing requirements of the new medical care laws, and our position is to their policies or requirements.

FORMS AND MEDICAL RECORDS FEES

Due to the increasing cost of providing our patient with the highest standards of care, we impose a charge for certain records and forms. It takes time from our practice, for the provider and staff to retrieve and copy files, completer forms, and write letters. The following charges apply:

FML, Disability, Green Corps, and supplemental insurance forms - $15.00

Dictated letters, extensive forms with review of medical records - $25.00

Copies of records for personal use will be charged the allowed fee by the state of California.

ASSIGNMENT OF BENEFITS

I request the payment of authorized Medicare and commercial insurance benefits be made on my behalf to the name of provider of service and/or supplier for any services furnished to me by that provider or service and/or supplier. I authorize any holder of medical information about me to be released to the Center for Medicare and its agents or any other insurer and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance, or any other health comp/medical plan to issue payment check(s) directly to William N. Sokol, MD, Inc. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

AUTHORIZATION TO RELAEASE INFORMATION

I hereby authorize William N. Sokol, MD, Inc to:

1. Release any information necessary to insurance carriers regarding my illness and treatments.
2. Process insurance claims generated during examinations or treatment.
3. Allow photocopy of my signature to be used to process insurance claims for lifetime period. This order will remain in effect until revoked by me in writing.

Medical authorization for release/disclosure of protected health information/HIPAA privacy notice has been provided.

_____

Patient Name Printed

_____ _____

Patient or Guardian Signature Date

_____

Relationship to Patient

William N. Sokol, M.D., F.A.C.P.

Diplomate American Board of Internal Medicine
Diplomate American Board of Allergy and Clinical Immunology

400 Newport Center Dr Ste. 406
Newport Beach, CA 92660
(949) 645-3374
(949) 645-2410 Fax

4950 Barranca Pkwy. Suite 306
Irvine, CA 92603
(949) 651-1427
(949) 651-1340 Fax

Authorization to Release Medical Records

Patient Information: Print Name:_____Date of Birth: _____

SSN#:_____Maiden or Prior Name _____

Please release my MEDICAL RECORDS from:

Name of Facility or Provider:

_____

Address:_____

City/ State/ Zip: _____

Phone Number: _____

Fax Number: _____

Please send my MEDICAL RECORDS to:

Name of designated recipient:

_____

Address:_____

City/ State/ Zip: _____

Phone Number: _____

Fax Number: _____

Information to be released:

- o The most recent 2 years of pertinent information (chart notes, labs, x-rays, and any special tests)
- o All medical records
- o Labs and/or x-rays only

Purpose for which disclosure isa being made:

- o Sharing with other healthcare providers
- o Legal investigation
- o Personal use
- o Transferring my care to another provider

☐ Other: _____

_____

Patient Authorization: I understand that the information in my health records may include information relating to sexual transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health, and treatment for alcohol and drug abuse. William N. Sokol, M.D. is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

My Rights: I understand that I do not have to sign this authorization to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorize to be disclosed reaches the noted receipt, that person to organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Fees for Copying Medical Records: William N. Sokol, M.D. will provide one complimentary copy of medical records to the patient. After which, there is a $25 fee for release of medical records directly to the patient (cash, checks, and visa/master cards). As a professional courtesy we will release medical records to another physician's office for no charge; however, a records release for each for each doctor must be obtained.

I understand that I may be charged at the rate shown above for the copies of records I have requested. I agree to pay the total charges upon receipt of the copies.

Patient or Guardian Signature_____Date:_____/_____/_____

William N. Sokol, M.D., F.A. C. P.

Diplomate American Board of Internal Medicine
Diplomate American Board of Allergy and Clinical Immunology

400 Newport Center Drive. Suite 406
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(949) 651-1340 Fax

ALLERGY INFORMATION

I. TREATMENT FOR ALLERGY

There are three principal methods of treating allergies, each of which requires cooperation between the physician and the patient. These forms of treatment are:

A. Avoidance (Environmental Control):

This means avoiding contact with substances to which you are allergic and eliminating them as far as possible. Included are such things as house dust, pets, feather pillows, etc., and in some cases certain foods and drugs. When the offending substance can be eliminated, this is the best form of treatment, and may be the only one required. If you do not follow the principles of avoidance explained to you by your physician, you will increase considerably the risk of having allergy symptoms. Unfortunately, may allergens including house dust, pollen and mold spores are difficult to eliminate and may be present in the air you breathe.

B. Medications:

Many kinds of medication may help patients with allergies. Many of these also have possible undesired side effects. Overuse or unsupervised administration of such medications can increase the risk of undesirable effects. Side effects of some frequently used antiallergic drugs include:

1. Antihistamines: Drowsiness; interference in operating machinery, including automobiles.
2. Bronchodilators: Nervousness; restlessness; upset stomach.
3. Cromolyn Sodium: Cough; occasional skin rash.
4. Xanthine (theophylline, aminophylline): anxiety; restlessness; vomiting.
5. Adrenalin (epinephrine): Pallor; rapid heart rate; nervousness; trembling and shaking.
6. Corticosteroids (Cortisone, prednisone, etc.): Undesired weigh gain; peptic ulcers, suppressions of the adrenal glands; reactivation of pre-existing tuberculosis; growth retardation; hypertension; increased blood sugar; and other disturbances. Risks are greatly minimized using small doses for short periods or intermittent rather daily administration. Risk is increased with large doses given daily over a long period of time.
7. Aerosols for inhalation: Restlessness; pounding heart; and loss of effectiveness, especially if taken more frequently or in greater amounts than prescribed. Large doses may cause fatal heart irregularities. Aerosols and epinephrine injections may also cause heart irregularities if given in rapid sequences.

Many of these side effects are due to over dosage.

C. Immunotherapy (hypo-sensitization or "allergy shots"):
In some patients, the Physician may decide that in addition to other forms of treatment, immunotherapy is indicated. Unfortunately, not everyone for whom the physician recommends

immunotherapy will benefit. It may be recommended when it is believed the likelihood of benefit from only environmental control and medications is small.

Immunotherapy is a long-term procedure and involves stepwise increases of large enough to stimulate an adequate immune response while avoiding a generalized reaction. A local reaction at the site of the injection is common and usually occurs soon after the injection as an area of redness or swelling. A record of the approximate size of such local reaction is usually large, or last many hours, or is accompanied by sneezing or coughing, it may indicate that a change in dosage should be made. Therefore, you should give your doctor such information before he gives the next dose.

You will be asked to remain in the office 30 minutes after injections are in administered to have the local reaction seen and recorded, and to threat any general reaction which may occur.

General ("constitutional") Reactions in addition to sneezing or coughing following a treatment, a general reaction may include widespread itching, hives, nasal discharge, wheezing, difficulty breathing, and low blood pressure. Such general reaction symptoms, while uncomfortable, are usually not serious if treated, which is an additional reason for waiting in the office after injections.

II. TESTS FOR ALLERGY

The tests most frequently employed are skin tests, either scratch or intradermal (needle).

A. Scratch tests

A drop of allergy extract is applied to the skin and a tiny scratch is made through the drop. The area is then observed for about 20 minutes. Positive reactions are usually manifest by an area of redness and itching at the site of the scratch. It may last an hour or two. Temporary increases or decreases in skin pigmentation may follow scratch testing. Rarely permanent change in skin pigmentation have occurred. "Constitutional reactions may also occur (as mentioned above).

B. Intradermal Testing

Intradermal testing involves the injection of a tiny amount of extract into the skin through a small needle. These tests are usually more sensitive than scratch test. A positive test resembles that describes for a positive scratch test. On rare occasions scratch or intradermal skin test cause a "constitutional" reaction (as mentioned above).

I do hereby certify that I have read the above information, and I am aware of the possible benefits and risk involved.

_____ _____

Patient or legal guardian's signature Date

PHARMACY FORM

Patient Name: _____

Date of Birth: _____

Cell Phone Number: _____

CURRENT PHARMACY INFORMATION

Pharmacy Name:_____**Phone Number**: (_____)_____-_____

Address:_____

_____

MEDICATION ALLERGI ☐ **YES** ☐ **NO**

LIST DRUG ALLERGIES:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please indicate any special instructions (i.e., liquid only)

_____

CURRENT MEDICATION LIST

MEDICATION	DOSE	FREQUENCY
1.		
2.		
3.		
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9.		
10.		
11.		
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14		
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19.		
20.		

William N. Sokol, Jr., M.D.
Loula A. Amin, M.D.
Diplomate American Board of Allergy
Diplomate American Board of Pediatrics
Diplomate American Board of Internal Medicine

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS HOW YOU CAN GET ACESS TOT HIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INOFRMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about your privacy practice, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 01/01/2009 and will remain effect until replace it.

We reserve the right to our privacy practices and the terms of this notice at any time, provided such changes are permitt ed by applicable law. We reserve the right to make changed in our privacy practices and the new terms of out notice effective for all health information that maintain, including health information we create or receive before we made the changes. Before we make significant changes in our privacy practices, we will change this notice and make the new one available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health operations, you may give us authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or location) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so; you must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $1.00 for each page, $15.00 per hours for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative formal, we will charge cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us suing the information listed at the end of this notice for full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 16 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosed of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. (Except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request

must specify the alternative means or location and provide satisfactory explanation how payment will be handled under the alternative means or location.

Amendment: you have the right to request that we amend your health information (your request must be in writing, and it must explain why the information should be amended). We may deny your request under circumstances.

Electronic Notice: If you receive this notice on our website or by electronic (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

400 Newport Center Dr Ste. 406
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(949) 645-2410 Fax

4950 Barranca Pkwy. Suite 306
Irvine, CA 92603
(949) 651-1427
(949) 651-1340 Fax

_____ _____/_____/_____

Patient Signature **Date**