TIDEWATER
ALLERGY & ASTHMA

PATIENT INFORMATION & REGISTRATION FORM

Patient Name: _____ Date: _____

Address: _____ DOB:_____

Email Address: _____ Phone: _____

SSN: _____ Do you have special communication needs:_____

Occupation: _____ Employer: _____

Sex: _____ Marital Status: _____ First Visit with Tidewater Allergy: Y or N

PCP: _____ Referring Provider: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Phone and Location: _____

Name of Primary Holder/Subscriber of Insurance Policy: _____

Insurance Company: _____Subscriber #: _____ DOB: _____

Do you have secondary insurance? Y or N **If yes, please list details of secondary insurance below.**

Name of Secondary Holder/Subscriber of Insurance Policy: _____

Insurance Company: _____ Subscriber #: _____ DOB: _____

It is the patient's responsibility to inform us of correct and up-to-date insurance information, and to correctly identify which insurance is primary. Incorrect info may lead to insurance denials and increased charges paid by the patient. Please provide us with each insurance card, along with Medicare/Medicaid cards, if applicable.

If you have Medicare or Medicaid, please list that ID number here as well: _____

You will need to provide all current and up-to-date insurance cards, as well as identification, at each visit.

(please continue to page 2 of this document)

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Emergency Contact Name: _____ Phone: _____

Address: _____ Relation: _____

For Pediatric Patients:

Responsible Party (if not the patient): _____

Birthdate: _____ Relationship: _____ Phone: _____

Mailing Address (if different from above): _____

Reason for Visit: We will have you complete a more thorough visit questionnaire when you come into the office on the day of your visit, but please let us know the main reason for your visit below.

Select all that apply

- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Drug Allergies
- ☐ Asthma/Breathing Issues
- ☐ Eczema
- ☐ Other Rash/Dermatitis
- ☐ Immune Concerns
- ☐ Other: _____

How did you hear about us? _____

TIDEWATER
ALLERGY & ASTHMA

Welcome Packet Signature Page
Financial Policy and Notice of Privacy Practices Acknowledgement

Welcome! Thank you for choosing Tidewater Allergy and Asthma. We are dedicated to providing high-quality care to all of our patients and look forward to partnering with you in your health. For your convenience, we have combined our Financial Policy and Notice of Privacy Practices into one document collectively called the "Welcome Packet." This first page of the "Welcome Packet" is the signature page, and then the policies are outlined on the following six pages.

Please review the Welcome Packet carefully, including the provisions that you are signing on behalf of the Responsible Parties (as defined in the Financial and Release of Billing Policy). If you have any questions, please do not hesitate to ask. For more information, please review our website at www.tidewaterallergy.com

This Welcome Packet includes:

- Tidewater Allergy & Asthma 2026 Notice of Privacy Practices
- Tidewater Allergy & Asthma 2026 Financial and Release of Billing Policy (including No-Show Policy)

I, _____ (patient/patient legal representative), hereby acknowledge that I have received a copy of the Forms listed above, including Tidewater Allergy & Asthma's Notice of Privacy Practices (Notice Regarding Privacy of Personal Health Information) and Tidewater Allergy & Asthma's Financial and Release of Billing Policy. **I have been provided a copy, read, understand, and will comply with the terms of Tidewater Allergy & Asthma's Financial Policy.**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected Health Information, referred to as PHI. I have had the opportunity to understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that Tidewater Allergy and Asthma has the right to change the *Notice of Privacy Practices* from time to time, and that I may contact Tidewater Allergy and Asthma at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient's Name: _____ Date of Birth: _____

Responsible Party: _____SSN of Responsible Party:_____

SIGNATURE: _____ Date: _____

Below is a list of persons who are authorized to view any medical information in this medical chart:

_____ _____

_____ _____

WELCOME PACKET: 2026 FINANCIAL AND RELEASE OF BILLING POLICY

We are dedicated to providing high-quality care to all of our patients and look forward to partnering with you in your health. Please read the following carefully as we want you to fully understand our financial policies. Feel free to ask us any questions. A copy will be provided to you upon request.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN WRITING IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

PAYMENT RESPONSIBILITY: The Responsible Parties (as defined hereinafter) agree to this Financial and Release of Billing Policy, including this Payment Responsibility section. **YOU, YOUR LEGAL REPRESENTATIVE (IF APPLICABLE), AND THE PLAN SUBSCRIBER (I.E., THE PERSON SUBSCRIBING TO OR CARRYING THE INSURANCE PLAN FOR THE PATIENT APPOINTMENT) (COLLECTIVELY, "RESPONSIBLE PARTIES") ARE ULTIMATELY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED. YOU REPRESENT AND WARRANT THAT THE INFORMATION PROVIDED TO TIDEWATER ALLERGY AND ATHMA IS ACCURATE AND THAT YOU POSSESS THE LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON BEHALF OF THE RESPONSIBLE PARTIES.** Payment is expected at time of service for all charges owed for the current visit as well as any prior balance.

INSURANCE: Please understand that your insurance policy is a contract between you and your insurance company, and we cannot assume that any specific charge will be covered. Co-payments, deductibles, and co-insurance are part of the contractual agreement between you and your insurance company. Your insurance company also requires us to collect your co-payment in full at the time of service. If your plan also has a deductible and/or co-insurance that has not been met, we may collect a deposit, as we can only estimate the amount due at the time of service. We encourage you to contact your insurance company and to become familiar with what your specific plan covers. **Once we submit the claim to your insurance company, which occurs after your visit, the insurance company will determine your eligibility and at that time provide the amount of your financial responsibility under your contract. If the insurance company deems that your patient responsibility is different than what we collected in the office, we will adjust your bill accordingly. If your insurance company states that you are ineligible for benefits, you will be responsible for the uncovered balance.** If you do not agree with the denial, you must resolve the matter with your insurance company. You may be asked to sign a form estimating charges for services that may be deemed non-covered by your insurance company. **YOU AGREE TO PROVIDE CURRENT INFORMATION FOR ALL PAYORS/INSURANCE COMPANIES FOR YOURSELF, AND ANY PATIENT ON WHOSE BEHALF YOU SIGN, PRIOR TO RECEIVING SERVICES. IF YOU PROVIDE AN INCOMPLETE OR INACCURATE LIST OF YOUR INSURANCE PAYERS, AND AS A RESULT CLAIMS ARE DENIED, YOU WILL BE RESPONSIBLE FOR THE UNPAID BALANCE.**

CO-PAYMENTS AND DEDUCTIBLE: All co-payments must be paid at the time of service. Each Responsible Party is responsible for your deductible and co-insurance according to your insurance plan.

OUTSTANDING BALANCE: You or a Responsible Party must pay any outstanding balance prior to scheduling any appointment for you or any member of your family.

SELF-PAY (NO INSURANCE): You will be required to pay in full at the time of service. Upon request, we will have a member of the business office discuss the cost of additional charges before we perform any testing.

CLAIMS SUBMISSION: We will submit claims to your insurance. We may, but are not required to, assist you in obtaining payment from your insurance company. Your insurance company may need you to supply certain information directly, and you must comply as directed. The balance of your claim is the responsibility of each Responsible Party regardless of payment by your insurance company.

REFERRALS: Insurance is a contract between you and your insurance company, and **it is your responsibility to know the requirements of your specific insurance plan. Some insurance plans require a referral authorization from your primary care physician or pediatrician in order to receive care from a specialist**. If we have not received a referral prior to your arrival at our office, you may be rescheduled. If your claim is denied because you do not have a referral when one was required, you will be responsible for the unpaid balance.

PROOF OF INSURANCE/ COVERAGE CHANGES: All patients must complete our Patient Information form. Also, we must obtain a copy of your driver's license and current valid insurance card(s) to provide proof of insurance. **If you fail to provide us with this information at the time of service, or fail to provide full, complete, and accurate information about <u>all</u> of your insurances, you will be responsible for the balance on your account.** Indeed, failure to provide accurate and complete insurance information can lead to denials and zero payment from your insurance, and thus the balance will become the patient's responsibility.

METHODS OF PAYMENT: We accept payment by Cash, Debit/Credit Cards, HSA cards, Cashier or Certified Check.

PATIENT STATEMENTS: If you have an unpaid balance, you will receive a statement via text, and then if not paid, you will receive a statement by mail. Statements will also be available online through the Patient Portal. The statement is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to our internal collection department and/or may be submitted to an outside collection agency with possible dismissal from the practice. Balances may also be submitted to our attorney for collection or legal filing.

COLLECTION FEES: Accounts submitted to the collection agency or attorney are not eligible for payment plans. All collection costs, including our attorney's fees, may be charged back to the account. Patients referred to the collection agency will be required to have prior approval before your visit is scheduled. If we, or our attorney, files a lawsuit to collect an outstanding balance, you and each Responsible Party agree to pay our reasonable attorney's fees if we prevail in our lawsuit. Accounts 60 days past due will be subject to interest at a rate of one percent per month, or the maximum rate allowed by law, whichever is greater.

RETURNED CHECKS: Your account will be charged a $35.00 service fee for checks not honored by your bank. The check and service fee must be paid in full before your next visit.

FORM FEES: There is a $25.00 fee to fill out forms up to 3 pages in length if requested or completed outside of a visit. Forms longer than 3 pages will be subject to additional cost. There is a $50 fee for letters

LATE ARRIVALS, CANCELATIONS, AND NO-SHOWS: Patients are expected to inform us if they are unable to make scheduled appointments, including if they will be late. Patients who arrive more than 15 minutes after an appointment's scheduled start time will be considered "Late." Late patients may be asked to reschedule or may be discharged from the practice.

Additionally, we kindly require patients to give at least two business days' notice if they will be unable to make a scheduled appointment. Last minute cancellations and no-shows deprive other patients of an opportunity to receive timely care by taking an appointment that could go to another patient. **With that, patients who call to reschedule with less than two business days' notice will be required to pay a $50 rescheduling fee. Patients who do not show up for a scheduled appointment will be considered a "No-Show" in each instance, and No-Show patients will be charged a rescheduling fee of $50.00 for each No-Show appointment. This will not be covered by your insurance company.** No-Show patients may also be discharged from the practice. Please also note that we will not reschedule a patient who is a no-show to their first new patient appointment.

RELEASE OF BILLING INFORMATION: I, the above-signed, consent to the use of my Protected Health Information for treatment and payment for treatment. I allow Tidewater Allergy & Asthma to bill my insurance and assign, except as otherwise provided by law or other agreement, directly to Tidewater Allergy & Asthma all medical benefit, if any, otherwise payable to me for services and supplies rendered. I understand that Tidewater Allergy & Asthma will share patient protected health information according to the federal and state law for treatment and payment, as well as in accordance with its Notice of Privacy Practices. I hereby authorize Tidewater Allergy & Asthma to release all information necessary to secure payment of benefits to my insurance company. I authorize the use of this signature on all insurance submissions.

I acknowledge and understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I acknowledge and understand that all charges remaining after insurance reimbursement will be billed.

This Financial and Release of Billing Policy is effective as of January 1, 2026.

WELCOME PACKET: 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.

Federal Regulations developed under the Health Insurance Portability and Accountability Act, as amended, (HIPAA) require that we provide you with this notice.

Uses and Disclosures

Treatment. We may use your protected health information, as defined under HIPAA (PHI) or disclose your PHI to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures may be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. We may use your PHI to seek payment for health care services that we provide to you, including from your health plan, from other sources of coverage such as an automobile insurer, workers compensation carrier or from credit card companies that you may use to pay for services, or consumer reporting agencies relating to collection of premiums or reimbursement. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health Care Operations. We may use your PHI as necessary to support the day-to-day activities and management. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement and Government Functions. We may disclose your PHI to the police or other law enforcement officials as required by law or in compliance with a court order. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

Coroners, Medical Examiners, Funeral Directors, Organ Donation. We may disclose your PHI to a coroner or medical examiner as authorized by law. Your health information may be disclosed to coroners and/or medical examiners for purposes of identification, determining cause of death, or other duties as required by law. We may also disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Public Health Reporting. We may disclose your PHI to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department, or to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed herein requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. We may use your PHI to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Research. Your protected health information will not be disclosed for research, unless written authorization is obtained.

Marketing. Your protected health information will not be used for marketing, unless written authorization is obtained. For example, we will not accept any payments from other organizations or individuals in exchange for making communications to you about treatments, therapies, health care providers, settings of care, case management, care coordination, products or services unless you have given us your authorization to do so or the communication is permitted by law. We may provide refill reminders or communicate with you about a drug or biologic that is currently prescribed to you so long as any payment we receive for making the communication is reasonably related to our cost of making the communication. In addition, we may market to you in a face-to-face encounter and give you promotional gifts of nominal value without obtaining your written authorization. We will not use your information for any type of fund-raising endeavor.

Prohibited Uses and Disclosures for Protected Health Information

Except as otherwise provided, we will not use your PHI as follows without your written authorization:

- We will not use your PHI, including your genetic information, for underwriting, determination of eligibility and benefits, computation of premium or contribution amounts, application of any pre-existing condition, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.
- We will not make any disclosure of Protected Health Information that is a sale of Protected Health Information without your written authorization. The sale of protected health information by the health care provider or its business associates for a fee. A cost-based fee for preparation and transmittal purposes to an authorized provider or insurance company is permissible.

For further information please visit the HHS website available at (as of March 31, 2024):
https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Individual Rights and Our Duties
You have certain rights under the federal privacy standards. These include:

- The right to request restriction on the use and disclosure of your protected health information.
- The right to Receive communications by alternative means or at alternative Locations. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to appoint someone your medical power of attorney or legal guardian, that person can exercise your rights and make choices about your health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Our Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our privacy practices. We are required to notify you of a breach, which results in the compromise of security or privacy of your protected health information. We are required to abide to the privacy policies and practices that are outlined in this notice (or other notice in effect at the time of the use or disclosure).

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from us and submit the completed form to us as directed on the form. If you request copies, we may charge you a reasonable copy fee.

Concerns. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Tidewater Allergy & Asthma
Attn: Privacy Officer for HIPAA
4543 Bonney Road, Suite B
Virginia Beach, VA 23462

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.