# 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 Primary 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.

Columbia Asthma & Allergy CLINIC

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# PATIENT REGISTRATION

**Date of Appointment:** _____

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

Mailing Address: _____

Email: _____ ***Ok to send email?*** ☐ **Yes** ☐ **No**

Home#: _____ Cell#: _____ ***Ok to send text?*** ☐ **Yes** ☐ **No**

Occupation: _____ Work#:_____

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**Responsible Party (if under 18)** :_____ Relationship: _____ DOB: _____

Mailing Address: _____

Phone#: _____ ***Ok to send text?*** ☐ **Yes** ☐ **No**

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

ID#: _____ ID#: _____

Group#: _____ Group#: _____

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

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

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**Emergency Contacts**

#1: _____ Phone: _____

#2: _____ Phone: _____

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**Were you referred to Columbia Asthma and Allergy Clinic by another provider?** ☐ **Yes** ☐ **No**

Referring Provider/Clinic: _____

Provider Address: _____

Physician Phone: _____ Physician Fax: _____

**If no, how did you hear about us?** ☐ Google ☐ Yelp ☐ Website ☐ Other, please specify:

**www.columbiaallergy.com**

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_____

**Billing Communication:**

There are occasions when one of our Billing Department staff members will need to verbally contact patients regarding their account. If we are unable to reach you and get a voicemail, do you authorize us to leave a voicemail? ☐ **Yes** ☐ **No**

Without written authorization, we cannot discuss account details with anyone other than the patient.

**Authorized Person to Speak on your Behalf:** _____ **Phone#**:_____

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**Late Cancellation Notice:**

We require a 24-hour notice for change of appointment or cancellation to try and fill your spot with another patient requesting our services. Failure to comply may incur a $100.00 fee.

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**Method of Payment:**

We accept cash, check, Care Credit (at many locations), and most major credit cards for your convenience. Returned NSF checks are subject to a $25 NSF fee and the Company will no longer accept checks from patients who have written a returned NSF check. These patients will be asked to pay in another accepted alternative means such as money order, credit card or cash for all future transactions.

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**Financial Policy:**

I acknowledge that I have read and/or been offered a copy of the Financial Policy and I understand the content of the policy. ☐ **Yes** ☐ **No**

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**HIPAA Policy:**

I acknowledge that I have read and/or been offered a copy of the HIPAA policy and I understand the content of the policy.
☐ **Yes** ☐ **No**

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*The above information is true to the best of my knowledge. I authorize my insurance benefits to 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.*

**Signature:**_____ **Date:** _____

# New Patient History Questionnaire

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

**Pharmacy/Address:** _____
**Phone #:** _____ **Fax #:** _____

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
- ❑ sinus pressure / pain
- ❑ frequent sinus infections (# per year_____)
- ❑ Nasal / Sinus Procedures (circle): surgery, sinus x-ray, sinus CT Date(s):_____

**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:_____)
- ❑ ENT evaluation (Date:_____)
- ❑ skin testing (Last Date:_____)
- ❑ blood testing (Last Date:_____)
- ❑ allergy shots (for ____ years and stopped in _____ (year)

**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 _____

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

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

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**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
- ❑ 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:**
- ❑ Age: _____

**Previous Testing/Treatment**
- ❑ Pulmonologist evaluation
  Last Date:_____
- ❑ Pulmonary function testing
  Date(s):_____
- ❑ Chest x-ray
  Date(s):_____
- ❑ ER visits
  - How many?_____
  - Last visit:_____
- ❑ Hospitalized _____ times
  Last hospitalization:_____
- ❑ Oral steroids: ____ courses/year
- ❑ Albuterol use:
  - ❑ ____ times per week
  - ❑ ✔ times per month

**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 occur in:**
- ❑ spring ❑ summer
- ❑ fall ❑ winter

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

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

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## Family History

If Unknown, check here: ☐

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

Autoimmune 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
Vaping/E-cigarette Use? ❑ yes ❑ no
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):_____

**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

Does your home have a basement? ❑no ☑ yes
(If yes, ❑ finished ☑ unfinished ❑ dry ❑ damp ❑ musty)
History of water damage at 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 ❑ indoor/outdoor
❑ allowed in bedroom
**Bed**: ❑ mattress/boxspring ❑ latex ❑ foam
❑ waterbed ❑ other_____
(Allergy encasement? ❑yes ❑no)
**Pillows**: ❑ feather ❑ non-feather
(Allergy encasements? ❑yes ❑no)

# FINANCIAL POLICY

As a courtesy, Columbia Asthma & Allergy Clinic, verifies your benefits before your first visit, or when your insurance coverage changes. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan's benefits. If your insurance company pays differently than estimated for any reason, you agree that you are responsible to pay any remaining balance within 30 days of notification of your balance. If after 60 days from filing your claim we have not received payment from your insurance carrier, we may ask you to pay the remaining balance on your account. Although we do our best to advocate for our patients and assist with benefits and eligibility, it is ultimately the patient's responsibility to know and understand your medical insurance coverage.

**We highly recommend that you also contact your insurance carrier and check into your coverage for allergy, asthma and immunology.**

***It is the policy of Columbia Asthma & Allergy Clinic that all patients pay their deposit, copay and/or coinsurance payment at the beginning of each visit***. If during the benefits investigation we notice a patient has an unmet deductible, a deposit toward services rendered will be collected at the time of service. The Patient Care Coordinator at your location will explain this information to you prior to your first visit. You will be billed for any outstanding balances from your visit once your insurance processes the claim. Balances are due to be paid within 30 days of notice of the balance. Further actions may be taken on any account not paid in full after the 30 day grace period.

As a courtesy we will be happy to bill your insurance. Please provide your insurance information to the front office staff. We do require a photocopy of insurance cards to be on-file, as well as all required information regarding the policy holder of the insurance plan(s) in which we are billing. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. If you have an HSA/FSA card please provide the information so that we may collect payment for balances using it.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services either. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

It is the patient's responsibility to ensure Columbia Asthma & Allergy Clinic has the current/active insurance(s) and updated mailing address on file, as well as other demographic information. Failure to do so may result in delayed claims processing or failure of you receiving notifications of balances and other important information. Columbia Asthma & Allergy Clinic will not be held responsible for having outdated information on-file. Columbia Asthma & Allergy Clinic will not retro authorize or process claims if updated insurance information is not provided to our staff prior to services being rendered.

**Method of Payment**
We accept cash, check, Care Credit (at many locations), and most major credit cards for your convenience. Returned NSF checks are subject to a $25 NSF fee and the Company will no longer accept checks from patients who have written a returned NSF check. These patients will be asked to pay in another accepted alternative means such as money order, credit card or cash for all future transactions.

**No Insurance Coverage**
For patients without insurance, payment in full at the time of service is required. Please notify the front desk staff prior to your appointment when you will be paying cash for your services.

**Usual & Customary Rate**
Our clinic is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. You are responsible for paying any balance in full, regardless of your insurance company's determination of usual and customary rates. If your insurance does not cover a specific treatment or service, you will be offered cash price rates to consider. In some cases, a cash price membership may also be available and designated staff members can be asked to contact you to discuss what may be best for your specific situation.

**Coordination of Benefits**
Columbia Asthma & Allergy Clinic is more than happy to bill more than one insurance on behalf of the patient, but the patient is responsible for coordination of benefits. If a patient has more than one insurance, it is the patient's responsibility to ensure all plans involved are aware of one another and the sequence of primary vs secondary is clear to all parties involved with the billing process. When issues present, it is the patient's responsibility to correct this with the payers and inform the Columbia Asthma & Allergy Clinic Billing Department staff when resolved so that corrected claims can be sent. Any unresolved problems in this regard may result in unpaid balances that will become patient responsibility if not resolved within 90 days of first claim submission.

**Appointment Cancellations and Electronic Communication**
We require a 24-hour notice for change of appointment or cancellation to try and fill your spot with another patient requesting our services. Failure to comply may incur a $100.00 fee. We appreciate you as a patient, and cooperation in complying with this policy will assist us in providing the best care possible to all of our patients.

**By signing below, I have reviewed and understand all content on this document**

_____ _____
Patient Name (*please print)* Date

_____
Patient/Responsible Party Signature

**Billing Communication**

There are occasions when one of our Billing Department staff members will need to verbally contact patients regarding their account. On the chance we are unable to reach you and get a voicemail, we ask that you check the appropriate box where you prefer to be contacted, including the number to call. This will allow us to leave more detailed information in our message to you. Please note this is only an authorization to specify what information we are allowed to leave on your voicemail if you do not answer when we call.

Patients over the age of 18 are ultimately responsible for any debt accrued on their account unless we have written authorization and acknowledgement from a third party accepting financial responsibility. For adult patients whose parents will be responsible for paying any debt accrued on the adult child's account, we require a specific form to be completed by the patient and parents. Without this written authorization we cannot discuss account details with anyone other than the patient as well. Please ask the front desk staff for the proper forms for this situation, if needed.

**I authorize the following and I understand I can opt out at any time by submitting a written request:**

☐ CAAC Billing Department Representative is authorized to leave a detailed voice message regarding my account on my home phone at: _____

☐ CAAC Billing Department Representative is authorized to leave a detailed voice message regarding my account on my cell phone at: _____

☐ CAAC Billing Department Representative may discuss my account and financial topics* only with the following listed person(s): _____

** This authorization DOES NOT authorize named individual(s) to have any discussion regarding the patient's medical record unless it directly relates to billing. Only as needed information is disclosed*

Patient/Responsible Party Signature Date

# 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 the 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 Services 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.