KARIM & BRANCH, PSC
Farhad Karim, M.D. FAAAAI Leslie B. Branch, M.D. FAAAAI
2387 Professional Heights Drive, Suite 60, Lexington, KY 40503 Office: 859-277-1137 Answering: 800-709-7606 Fax: 859-278-0111

PLEASE DO NOT WRITE IN THIS SPACE—FOR OFFICE USE ONLY

PLEASE ANSWER QUESTIONS BELOW TO THE BEST OF YOUR KNOWLEDGE

SEASONAL INCIDENT: Winter, Spring, Summer, Fall - Perennial

AGGRAVATING FACTORS: (Circle) Dust (Type _____), Dog, Cat, Feathers, Cattle, Horses, Wool, Mohair, (Furniture, Sweaters, Etc.), Angora, Furs, Kapok, Barn, Hay, Tobacco (Housing, Around, Stripping), Colds, Odors (Cooking, Gas, Perfume, burning, Etc.), Cosmetics (Skin or Respiratory), Smoke, Leaves, Mowing, Pollen _____. Plants _____, Foods (worse after a meal) _____, Fatigue, Exertion, Air Conditioning, Excitement, Worry, Weather (which type) _____, Changes in Temperature, Drafts.

Are you worse indoors or outdoors, work or school? Is there a time of day worse for you – morning, afternoon, evening, night. Do you have frequent colds? If yes, how often _____. How many times a year do you need antibiotics? _____ Do you use nasal spray? _____

INSECTS: Mosquito, Bee, Wasp, Etc. Local swelling: _____ Systemic reaction: _____

DRUG ALLERGY: (Drug name and describe whether local or systemic and symptoms)

PAST HISTORY:

YOUR Dr. Name:_____ Date Last Seen:_____

OTHER Dr. Name:_____ Date Last Seen:_____

PHYSICIANS Dr. Name:_____ Date Last Seen:_____

Serious illnesses: (with dates and location of hospital)

Injuries:

Immunizations: TB Skin Test Date: _____ Results: _____

Surgery: (type, date, location)

Colic: (from what and how long)

Eczema: (from what and how long)

"Sinus"

Hay Fever: (age of onset, how long, seasonal or perennial)

Asthma: (age of onset, how long, seasonal or perennial)

Hives:

PREVIOUS ALLERGY TESTS: When: _____ From Whom: _____ Address: _____

Treatment: _____ How long: _____ Results: _____

Medications: (currently using)

Weight loss or gain: (over how long) _____ Present weight _____ Height _____

Teeth: (false, filled, pain, gums) _____ Date of last dental x-ray _____

Skin: Rash (location, does it come and go) _____
Dandruff, athletes foot, toenails (hard cut), itching (when is it worse) _____

Nose: Stopped up, Sneezing, Itching, Rubbing, Drainage from nose (clear, bloody, yellow, green, milky),
Sense of smell, Post nasal drainage (clear, bloody, yellow, green, milky), "Hawking", Sniffling.

Throat: Soreness, Clearing, Hoarse, Difficulty in swallowing, Swelling, Itching.

Ears: Hearing OK (L or R), Noise, Dizzy, Ache, Fullness, Popping, Cracking, "Stopped up or full", Itching (inside or outside)

Eyes: Itching, Tearing, Burning, Redness, Swelling, "Ropy" Secretions, Lids bother (swelling or matting)

Chest: Wheeze, Cough (sputum – bloody, yellow, green), Short of breath on exercise, at rest, at night – what time _____
Medicine used _____, Chills, Night sweats

Cardiac: Rapid heart, palpitation, ankles swelling

X-ray: When _____, Where _____, Results _____

G.I.: Appetite _____, Gas _____, Pain _____, Indigestion, Nausea, Vomiting, Diarrhea, Constipation,
Stools – bloody, tarry, mucous, worms, foamy, bulky. If any food products above, list:

Headache: Location _____ Move any place _____ How often _____
How long does it last _____ Does it throb _____ (Beat, drum or pound with pulse) or is it steady,
Vomit, Nausea, Blind spots, Sweating, Flushing, Related to - (nose, eyes, tension, fatigue, period).
Warning _____ Relieved by_____

G.U.: Frequency _____, At night _____, Burning, Bloody, Cloudy urine.

GYN: Regular \ Irregular periods _____, How affect allergy _____, Last period _____,
Hot flashes _____, Discharge _____, Itching _____,

Endocrine: Goiter, Prefer hot or cold weather, Dry skin, Joint pain, Fall asleep in chair,
Tired all the time, Difficulty thinking clearly, Thirsty, Frequent urination.

FAMILY HISTORY: Do any of the following, including Uncles, Aunts, Grandparents (either side), have asthma, hay fever, hives, eczema, sick headaches, sinus. Who: Father _____, Mother _____, Sisters _____,
Brothers _____, Others _____
If Married or Divorced, How long? _____ Children _____ Any Allergic? _____
Are they healthy? _____

SOCIAL:
Smoke _____ When Started _____ How Many _____
Contacts at work – Dust, Fumes, Chemicals, etc. _____
Drink: Social _____ None _____ How Much _____
Hobbies: _____

ENVIRONMENT:
Living conditions – _____ Type of House – (Frame, brick, etc.) _____
Basement – (moldy or dry) _____ Plants in home _____
Pets – Dog, Cat, Bird - _____ Indoors or Outdoors
Furniture in house – Plastic, Cotton, Wool, Foam rubber, Feather or down _____
Carpeting – What type _____ Mat under it _____
Heating system _____
Bedroom _____ Books, Toys, Pillows (Feathers, Dacron, Foam, Plastic Cover),
Mattress (feathers, innerspring, cotton, foam, plastic cover), Drapes, Venetian Blinds,
Stuffed chairs, _____ Rugs _____ How many and what type? _____

N.P.: Nervous, Irritable, Blue or Depressed, Insomnia, Worried about something, Family, Children, Husband, Wife, Mother, Father, Job, etc

PATIENT REGISTRATION FORM

Date Completed:_____

Patient Name:

Mailing Address:

City: **State:** **Zip:**

Physical Address if different from Mailing Address:

Home Phone: **Cell Phone:** **Work Phone:**

Birth Date: **Age:** **Social Security #:**

Employer: **Occupation:**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Widowed**

Smoker: ☐ **Yes** ☐ **No** **If Minor Mother's Name:**_____

Sex: ☐ **Male** ☐ **Female** **Child: Father's Name:**_____

Race: _____

For a minor child, to whom should we address correspondence (i.e. lab results, etc.)? _____

_____

Relative On Treatment Here: _____

How did you hear of our practice?

☐ **Friend** ☐ **Relative** ☐ **Telephone book** ☐ **Internet listing** ☐ **www.karimbranch.com** ☐ **Other**

RESPONSIBLE PARTY:

Name: **Social Security #:**

Mailing Address:

City: **State:** **Zip:**

Home Phone: **Work Phone:**

PRIMARY INSURANCE INFORMATION:

Company:

Address:

I.D. # **Group #:**

Insured Name: **Phone:**

Patient's Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

SECONDARY INSURANCE INFORMATION:

Company:

Address:

I.D. # **Group #:**

Insured Name: **Phone:**

Patient's Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Name of Referring Physician:

Address of Referring Physician:

Name of Family Physician:

Address of Family Physician:

Name, Address & Phone # of nearest relative (*not living with you*):

Primary Pharmacy & Phone #:

I authorize the release of any medical information necessary to process insurance claims filed on my behalf. I authorize payment of medical benefits to be made directly to the physician for services performed. I UNDERSTAND THAT I AM RESPONSIBLE TO KARIM & BRANCH, P.S.C., FOR ANY CHARGES INCURRED IN THE COURSE OF MY TREATMENT.

Patient/Guarantor or Guardian of Minor/Incapacitated Patient **Date Completed**

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Asthma, Allergy & Immunology
Pediatric & Adult

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.

Karim and Branch P.S.C. is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

This notice describes how we may use or disclose your "protected health information" for various purposes. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and relates to your past, present, or future physical or mental health or condition and related health services.

Karim and Branch P.S.C. is required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. Upon your request, we will provide you with any revised Notice of Privacy Practices by contacting the Office Manager at (859) 277-1137.

Uses and Disclosures of Protected Health Information Based upon Your Written Consent

We will ask you to sign a consent form. Once you sign that form, you have consented to the use and disclosure of your protected health information for treatment, payment, and health care operations. Your protected health information may then 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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of this practice.

Following are examples of the types of uses and disclosures of your protected health care information that the practice is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: Making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Uses and Disclosures That May Be Made With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless permitted or required by law as described below. You may revoke such an authorization, at any time, in writing, except to the extent that your physician or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Uses and Disclosures That May Be Made Unless You Object

We may also use or disclose your protected health information in the following instances. In these instances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are not able to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death.

***Disaster Relief*:** We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

***Required By Law*:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may use or disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

***Health Oversight*:** We may use or disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may use or disclose your protected health information to public officials who are authorized by law to receive reports of abuse, neglect, or domestic violence.

Food and Drug Administration: We may use or disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may use or disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

***Law Enforcement*:** We may also disclose protected health information for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) requests for limited information for identification and location purposes, (3) requests pertaining to victims of a crime, and (4) alerting law enforcement officials when (a) there is suspicion that death has occurred as a result of criminal conduct, (b) in the event that a crime occurs on the Practice's premises, or (c) a medical emergency exists (not on the premise) and it is likely that a crime has occurred.

***Coroners, Funeral Directors, and Organ Donation*:** We may disclose to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may also disclose such information on reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

***Research*:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

***Threatening Activity*:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by Secretary of the Department of Health and Human Services to investigate or determine our compliance with the privacy standards applicable to your protected health information.

Your Rights Regarding Your Protected Health Information

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be revisable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Contact if you have any questions about access to your medical record.

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Asthma, Allergy & Immunology
Pediatric & Adult

- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by writing to our Privacy Officer at 2387 Professional Heights, Suite 60, Lexington, KY 40503.

- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basic reason for the request. Please make this request in writing to our Privacy Officer.

- You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical records.

- You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Making a Complaint

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact one of our Privacy Officers, Marlene Adams or Susan Bias, at (859) 277-1137 or 2387 Professional Heights, Suite 60, Lexington, KY 40503 for further information about the complaint process.

This notice was published and becomes effective on April 1, 2003.

Farhad Karim, M.D., FAAAAI
Leslie B. Branch, M.D., FAAAAI

Karim & Branch P.S.C.
Asthma, Allergy & Immunology
Pediatric & Adult

2387 Professional Heights Dr., Ste. 60
Lexington, Kentucky 40503

I hereby consent to Karim and Branch, P.S.C. using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me, or to carry out the Practice's health care operations.

I understand that the Practice may condition its diagnosis or treatment of me upon my consent to allow its use or disclosure of my protected health information.

I acknowledge the Practice has offered me a copy of its Notice of Privacy Practices, which provides me a more detailed description of the uses and disclosures allowed by this consent, and that I have accepted said copy. _____. The Practice preserves my right to review the Notice of Privacy Practices prior to signing this consent.

I acknowledge the Practice has offered me a copy of its Notice of Privacy Practices, but that I have refused said copy._____ I may obtain a current copy at a date in the future by submitting a written request to 2387 Professional Heights Drive, Suite 60, Lexington, KY 40503.

I understand that I have the right to request restrictions on how the Practice uses and discloses of my protected health information for treatment, payment, or the health care operations. The Practice is not required to agree to any restriction, but if it does, the restriction is binding on the Practice.

I have the right to revoke this consent in writing, except to the extent that the Practice has taken action in reliance on this consent.

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights regarding my protected health information.

_____
Signature of Patient or Personal Representative

_____
Please Print Name of Patient or Personal Representative

_____
Date Completed

_____
Description of Personal Representative's Authority