Imtiaz Ahmed, M.D.

Diplomate of American Board of Allergy & Immunology
A Conjoint Board of American Board of Pediatrics and the American Board of Internal Medicine

Telephone (407) 846-4000 • Fax (407) 846-4808
903 West Oak Street
Kissimmee, FL 34741

3106 17th Street
St. Cloud, FL 34769

www.drahmed.com

Dear Patient:

Welcome to Asthma, Allergy & Immunology Center. Dr. Ahmed is a Board Certified Asthma, Allergy, and Immunology specialist who treats recurring ear and sinus infections, asthma, persistent cough and congestion; skin, food, insect, and drug allergy; ear, nose, throat, and sinus allergies and immune system disorders. All patients are expected to have their own primary care physician. In the event that you or your child requires Emergency Room Care or Hospitalization, you should contact your Primary Care Physician.

"OUR FEE POLICY"

As the patient, you are responsible for payment of any deductibles, co-payments, percent responsibility, uninsured services, or non-covered services including lab work and other procedures. We ask our patients to please remember that high administration costs are often what leads in increased fees. The billing and collection process is an expensive one, and that is why we ask our patients to pay at the time of service. If for some reason you are unable to make full payment at the time of service, please see the receptionist to make payment arrangements before your visit with the doctor.

Extra insurance forms, medical records, or special letters to insurance companies or lawyers require an extra fee due to the considerable amount of secretarial time involved. The patient's records are property of Asthma, Allergy, & Immunology, P.A., but copies of records may be obtained at a rate of $1.00 per page up to 25 pages and 25 cents thereafter. Please allow two weeks for processing.

If you are an HMO patient, please be sure to have your referral with you at the time of your visit. Please be thorough with your insurance information. You will be responsible for any unpaid balances due to lack of information. It is your responsibility to make sure we receive prompt payment from them. If your insurance denies payment on your account, you will be responsible for payment. If you do not pay in a timely fashion, your account may be subject to financial charges.

Physicians and staff of AAIC will not be responsible for the risks involved to the patient by non-compliance on follow-up appointments and tests or procedures previously ordered. I hereby authorize and direct. Dr. Imtiaz Ahmed, M.D., associates or assistants to provide such additional services as they deem necessary and reasonable, including, but not limited to administration of any anesthetic agent, laboratory or injection services, ly upon my consent.

I consent to treatment necessary in this clinic **(Asthma, Allergy, & Immunology, P.A.)**
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Asthma, Allergy, & Immunology, P.A., Inc., and authorize transfer of all unpaid amounts to my Visa/MasterCard/Discovery card after 120 days from the date of service.
I understand that payment of charges incurred is due at the time of service unless definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of charges.
I further authorize and request that insurance payment be made directly to Asthma, Allergy & Immunology, P.A., Inc should they elect to receive such payments.
I have read and fully understand treatment, financial responsibility, and patient private practice that was provided to me.

Your method of payment will be: **Credit Card** **Cash** **Check** **Insurance**
There will be a **$25.00** charge for returned checks and missed appointments.

Missed appointments will be charged to you as follows:
Office visit – **48 hrs notice – $25.00** **Skin** Test – **48 hrs notice – $50.00** **Breathing** Test – **48 hrs notice – $50.00**

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this practices originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care, i.e. consultations and referrals
- A source of information for applying my diagnosis and treatment information to my bill, for payment purposes.
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have read and acknowledged this form, I am aware that my signature is on file and I will comply.

Our Mission is to Educate, Prevent, Test and Treat Allergic, Respiratory and Immunologic Diseases

ASTHMA, ALLERGY & IMMUNOLOGY P.A.
CARE CENTER

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CONSENT FOR ALLERGY TESTING, TREATMENT, VACCINATION, AND IMMUNOTHERAPY

I authorize and direct Imtiaz Ahmed M.D. and associates or assistants of his choice to perform upon: Patient Name: _____ the following diagnostic procedure and treatment: allergy skin testing with inhalants, food extracts, insect venom, medication, chemicals, metals, allergy injections, pneumococcal, and influenza vaccination.

Allergy Test: in general terms, the nature and purpose of this diagnostic procedure is to inject small quantities of the extract in order to produce a localized wheel and flare (hive) reaction to determine the sensitivity (allergy) to any of them.

Allergy Immunotherapy: (allergy injections) involves injections of serial and increasing concentrations of special extract (serum or vaccine). The extracts are individually tailored with the allergens (i.e. dust, mold spores, pollens, and dander) that he/she is found to be allergic to. The dose and concentration of the extracts is gradually increased based on his/her ability to tolerate injections. A basic physiologic consequence of this treatment is the stimulation of the blocking antibody production, which causes a reduction in the offending substances side effect on the nose, throat, eyes, and bronchial tree etc. Immunotherapy or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any of the following symptoms: coughing, itching, eyes, nose, or throat nasal congestion, runny nose, tightness in the throat or chest, increased wheezing, lightheadedness, faintness, nausea and vomiting, hives, generalized itching, and shock the last under extreme conditions. Reactions, even though unusual, can be serious but rarely fatal. You are required to wait in the medical facility in which you receive the injections for at least 20 minutes after each set of injections; our office is equipped to handle any untoward reactions.

I have read the patient information sheet on above mentioned procedures and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy testing, immunotherapy and vaccination. These questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

This consent form is valid until it is expressly revoked and the revocation is communicated to my physician in writing. I understand and agree that it's my responsibility to communicate any revocation of this consent to my physician.

I hereby consent to receive allergy injections, if so prescribed for my allergies. I understand that I must wait 20 minutes after each set of injections for my own protection and that the allergen vials are made especially for me. If for some reason I choose not to continue immunotherapy, I will be responsible for any deductible, copayment, un-insured amount, or percentage for the vials that have been made.

Printed Name of Patient _____

Patient Signature (or parent of minor) _____ Date: _____

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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this practices originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care, i.e. consultations and referrals
- A source of information for applying my diagnosis and treatment information to my bill, for payment purposes.
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided the opportunity to review the "Patient Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "Patient Privacy Practices" prior to acknowledging this consent.
- The right to restrict or revoke the use or disclosure of my health information for purposes other than treatment or payment.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

estrictions:

I request the following restrictions to the use or disclosure of my health information

_____

If there is anyone you do not want us to discuss your healthcare information with, please list their names and relationship below

_____

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and or other individuals or agencies as permitted or required by state or federal law.

I fully understand the information provided by this consent.

_____ _____ _____

Signature | Print name of person signing | Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? [ ] Yes [ ] No

Print Child Name:

FOR OFFICE USE ONLY

[ ] Patient refused to sign the consent form.
[ ] Reason for patient's refusal to sign _____
[ ] Restrictions were added by the patient (see restrictions listed above)
[ ] "Consent form" received and reviewed by _____ on (date) _____