KRATZ ALLERGY, ASTHMA AND IMMUNOLOGY
CONSENT FORM AGREEMENT

CONSENT TO TREATMENT:

I consent to the examinations, treatments, and procedures that may be performed during my affiliation with Kratz Allergy, Asthma & Immunology. If I am the representative/ responsible party for another person or a minor, I also provide such authorization. This will include radiological examinations, laboratory procedures, medical and non-invasive treatments or procedures, or other medical or medically related services rendered to the patient under the general and special instructions of the physician(s) or allied health provider(s) of Kratz Allergy, Asthma and Immunology. Additional consent may be required for surgical or invasive procedures.

INITIAL _____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I understand and agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, Kratz Allergy, Asthma and Immunology may disclose information in the patient's record to any person or entity that is or may be liable for all or any portion of Kratz allergy, Asthma and Immunology's charges, included but not limited to, insurance companies, health care service plans, or worker's compensation carriers. The undersigned further consents to release of information in the patient's record to other health care providers, referring physicians and to outside medical facilities as is appropriate to expedite medical care. Medical information may also be used for confidential quality care studies.

INITIAL _____

LIFETIME AUTHORIZATION - MEDICARE CERTIFICATION FOR PAYMENT:

I certify that the information given by me in applying for payment under Titles XVII or XVIII of the Social Security Act (i.e., Medicare) is accurate and correct. I authorize any holder of medical or other information about the patient or myself I represent, to release to the Social Security Administration or its intermediaries or carries any information or documentation needed for this or a related Medicare claim. I request that the payment of authorized benefits payable for physician services to the physician or organization furnishing the services, and hereby authorize such physician or organization to submit a claim to Medicare for payment.

ONLY IF YOU HAVE MEDICARE, INITIAL _____

ASSIGNMENT OF INSURANCE OR THIRD PARTY BENEFITS:

I authorize direct payment to Kratz Allergy, Asthma & Immunology of any insurance, managed care, self-insured plan, or other third party benefits or state disability benefits otherwise payable to or on behalf of myself or the patient for services rendered, and assigned Kratz Allergy, Asthma & Immunology, for application on patient's account, all such benefits, payable at a rate not to exceed Kratz Allergy, Asthma & Immunology's regular rates and charges. I understand that I, or the patient I represent, will remain responsible for all charges or applicable co-payments not covered in whole or in part by the payer, subject to applicable law.

INITIAL _____

FINANCIAL RESPONSIBILITY AGREEMENT:

By signing this agreement, whether signing as patient, representative or guarantor, I fully understand and hereby acknowledge and agree that, if the services to be rendered are not covered by insurance, as an employee benefit program, Medicare, Medicaid, or a health maintenance organization, then I am directly and completely responsible to Kratz Allergy, Asthma & Immunology for payment of all charges. I also understand that I am responsible for all charges if I am covered by health insurance or a health maintenance organization with which Kratz Allergy, Asthma & Immunology does not hold a contract. Payment for any such services shall become due and owing when the services are rendered, and I agree to be liable for the payment of the services, provided that Kratz Allergy, Asthma & Immunology will attempt to obtain payment for any such services from the insurance or employee benefit program and its affiliated physician(s) and allied health provider(s) in consideration for Kratz Allergy, Asthma & Immunology's administration of any insurance claims. I further understand and agree that my obligation to pay is not contingent on any settlement, judgment, or verdict that I may eventually recover from my third party, and that payment is due and must be paid upon demand by Kratz Allergy, Asthma & Immunology. Should the account be referred to an attorney or collection agency for collection, I shall pay my balance and actual attorney's fees and collection expenses, which will be an additional 50% of my balance.

NSF fees on any returned checks will be $35.00.

INITIAL _____

Please be aware that Dr. Kratz and Dr. Guttridge utilize E-Prescribing to send all prescriptions they deem necessary. The financial responsibility for these prescriptions will be yours.

INITIAL _____

I certify that I have read the foregoing, and I am the patient, guarantor, or the patient's representative duly authorized to execute this agreement and accept its terms.

_____
Date and Time

_____
Witness Signature

_____
Print Name

FOR OFFICE USE ONLY

_____
Print Patient Name

_____
Signature of Patient/Guardian

IF SIGNED BY SOMEONE OTHER THAN THE PATIENT, STATE REASON

KRATZ ALLERGY, ASTHMA & IMMUNOLOGY
JAIME KRATZ, MD
RANDALL GUTTRIDGE, DO
727-819-1610

Name: _____ Date_____ Referred By: _____

Date of Birth ____/_____/_____ Age _____ Sex: M OR F Occupation/Student _____

Symptoms/Reason for Visit _____

When did the symptoms first occur? _____

How often do they last? _____How often do they occur? _____

What months are more severe? _____

What makes symptoms worse? _____

What makes symptoms better? _____

What do you think causes these symptoms? _____

CIRCLE ALL SYMPTOMS

General: Fevers, Chills, Sweats, Weight Loss, Frequent Infections, Fatigue

Headache: Location _____, Aching, Throbbing, Sharp, Dull

Eyes: Watery, Itching, Redness, Discharge, Puffiness, Infections, Pain

Ears: Pressure. Itching, Discharge, Bleeding, Frequent Infections

Nose: Stuffy, Drippy, Itching, Sneezing, Sniffles, Post-nasal drip, Mouth Breather, Snoring, Bleeding, Sinus Problems, Polyps, Trouble smelling, Broken Nose, Previous surgery

Tongue: Swelling, Itching, Coated

Mouth/Throat: Itching, Frequent throat clearing, Morning sore throat, Bad breath, Change in voice, frequent tonsillitis or infections, swollen lips

Mucus: Color _____ from: Nose, Lungs, Throat

Chest: Asthma, Bronchitis, Cough, Wheeze, Shortness of breath, Chest tightness, Pneumonia, Cough after exercise, Chest Pain, Trouble walking, Trouble sleeping

Stomach: Vomiting, Diarrhea, Reflux, Gas, Ulcers

Joints: Arthritis, Pain, Stiffness, Swelling, Warmth, Redness

Skin: Rash, Hives, Eczema, Blisters, Itching, Swelling, Burning, Redness

LIST ALL MEDICAL PROBLEMS:

Hospitalizations/Surgeries: _____

Reactions to Foods: _____Reactions to Medications:_____

Reactions to Insect stings: _____ Reactions to Immunizations: _____

LIST CURRENT MEDICATIONS, STRENGTHS AND FREQUENCY (Prescriptions, over the counter, eye drops, Etc. Attach a separate sheet if needed)_____

_____

_____

_____

Kratz Allergy, Asthma & Immunology
Jaime Kratz, MD
8202 Washington St.
Port Richey, Fl 34668
727-819-1610

SOCIAL SECURITY # _____ - ___ - _____

PATIENT'S NAME: _____ CIRCLE: MR. MRS. MS. MISS

CIRCLE: MALE / FEMALE DATE OF BIRTH: / / AGE: _____ MARITAL STATUS_____ RACE_____

STREET ADDRESS & APT#: _____

CITY: _____ STATE: _____ZIP CODE: _____

HOME TELEPHONE #: (____) _____ WORK TELEPHONE #: (____) _____

CELL TELEPHONE #: (____) _____ DRIVER'S LICENSE #: _____

PHARMACY: LOCAL: _____ MAIL AWAY: _____

LOCATION_____

MAILING ADDRESS IF DIFFERENT FROM ABOVE: _____

CITY _____ST_____ZIP_____

(IF PATIENT IS UNDER 18, PLEASE COMPLETE)

MOTHER'S NAME: _____ FATHER'S NAME: _____

ADDRESS: _____ ADDRESS: _____

CITY:_____ST _____ZIP: _____ CITY:_____ ST:_____ ZIP_____

PHONE: _____ WORK: _____ PHONE: _____ WORK: _____

PRIMARY CARE PHYSICIAN: _____TELEPHONE #: (____) _____

PRIMARY ADDRESS (IF KNOWN) _____

REFERRED BY DR: _____

REFERRED BY ANOTHER PATIENT (NAME PLEASE)_____

EMERGENCY CONTACT: _____ RELATIONSHIP TO YOU: _____

HOME PHONE#: (____) _____WORK (___)_____CELL# (____)_____

~~**PRIMARY INSURANCE COMPANY**~~ ~~**SECONDARY INSURANCE COMPANY**~~

~~NAME OF INSURANCE CO: _____~~ ~~NAME OF INSURANCE CO: _____~~

~~__HMO __PPO __PPC __OTHER~~ ~~__HMO __PPO __PPC __OTHER~~

~~INS CO ADDRESS: _____~~ ~~INS CO ADDRESS: _____~~

~~INS CO PHONE #: (____)_____~~ ~~INS CO PHONE #: (___)_____~~

~~MEMBER #: _____~~ ~~MEMBER #: _____~~

~~GROUP #: _____~~ ~~GROUP #: _____~~

~~POLICY HOLDER'S NAME: _____~~ ~~POLICY HOLDER'S NAME: _____~~

~~RELATIONSHIP TO PATIENT: _____~~ ~~RELATIONSHIP TO PATIENT: _____~~

~~POLICY HOLDER'S EMPLOYER: _____~~ ~~POLICY HOLDER'S EMPLOYER: _____~~

~~POLICY HOLDER'S DATE OF BIRTH: _____~~ ~~POLICY HOLDER'S DATE OF BIRTH: _____~~

STAY NOTIFIED!!

PLEASE PRINT EMAIL ADDRESS (CLEARLY) _____

DATE_____ **PATIENT/PARENT/GUARDIAN SIGNATURE**_____

KRATZ ALLERGY

Asthma and Immunology

JAIME KRATZ, M.D.

"NO SHOW APPOINTMENT POLICY"

Kratz Allergy, Asthma, and Immunology is pleased that you have selected us to assist in your medical care- but missing scheduled appointments jeopardizes optimal care outcomes.

So this doesn't occur we have adopted the following procedure:

- ***First missed appointment: we will call you to reschedule.***
- ***Second missed appointment: you may call and reschedule. You will receive a copy of this policy, and may be charged up to $35.00 for a missed appointment.***

Your third missed appointment may result in discharge from our practice.

- ***If you do not cancel your procedure 24 hours prior or you do not show for your procedure you will incur a minimum fee of $25 per procedure that you are scheduled for in any 24 hour period. A copy of this procedure will be furnished to the patient and a copy kept in their chart.***

Your good health and well being is our goal, a physician and patient partnership is the best way to achieve this.

THANK YOU FOR BEING OUR CUSTOMER
KRATZ ALLERGY

PT. SIGNATURE _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, KRATZ ALLERGY, ASTHMA & IMMUNOLOGY may use and disclose protected health (PHI) about me to carry out treatment, payment, and healthcare operations(TPO). Please refer to KRATZ ALLERGY, ASTHMA & IMMUNOLOGY'S Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. KRATZ ALLERGY, ASTHMA & IMMUNOLOGY reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to KRATZ ALLERGY, ASTHMA & IMMUNOLOGY Privacy Officer at 8202 Washington St., Port Richey, FL 34668

With my consent, KRATZ ALLERGY, ASTHMA & IMMUNOLOGY may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, KRATZ ALLERGY, ASTHMA & IMMUNOLOGY may mail to my home or designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked Personal and Confidential.

With my consent, KRATZ ALLERGY, ASTHMA & IMMUNOLOGY may e-mail to me appointment reminder cards, and patient statements. I have the right to request that KRATZ ALLERGY, ASTHMA & IMMUNOLOGY restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent.

_____ _____

Patient's Name **Date**

_____ _____

Signature of Patient or Legal Guardian **Print Name of Legal Guardian**

The following people may have complete access to my medical and appointment information.

NAME	**RELATIONSHIP/PHONE NUMBER**
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT SELF DETERMINATION ACT QUESTIONAIRE

Please Fill out this Form of Compliance with the Patient Self Determination Act passed by the State of Florida.

You cannot remove all uncertainty about your future healthcare needs but by having an advance directive you can have the peace that comes from making your wishes known in advance!

Declaration To Decline Life-Prolonging Procedures (Living Will)

[ ] I have made a Living Will.

[ ] I do NOT have a Living Will.

Health Care Surrogate

[ ] I have designated a Health Care Surrogate.

[ ] I have NOT designated a Health Care Surrogate.

Durable Power of Attorney

[ ] I have appointed a Durable Power of Attorney for Health Care decisions.

[ ] I have NOT appointed a Durable Power of Attorney For Health Care decisions.

_____

(Print Name)

_____ _____

Signature of Patient or Representative Date

If you have executed an Advanced Directive in any of the above formats, have you provided this office with a copy for your medical records? Yes ____ No ____

If you have any further questions, you can contact your family attorney, local hospital, local medical association, or our office for additional information.

Omnibus Budget Reconciliation Act of 1990 (Patient Self-Determination Act) Chapter 765, Florida Statutes.

BayCare Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange **(BayCare eHX)** is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

❑ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

❑ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

_____ _____ _____

Printed Name of Patient/Representative | Signature of Patient/Representative | Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____

BayCare Health System

Electronic Medical Records

Details About Your Health Information in BayCare eHX and the Consent Process:

1. **How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX **only**:
   - To provide you with medical treatment and related services
   - To check whether you have health insurance and what it covers
   - To evaluate and improve the quality of medical care provided to all patients
   - For administrative management of the BayCare eHX
2. **What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access **ALL** of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
   - Substance abuse
   - HIV/AIDS
   - Psychiatric/mental health conditions
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Sexually transmitted diseases
3. **Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
4. **Who May Access Information About You, If You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
5. **Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
6. **Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
7. **Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. **Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.**
9. **Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.