Vicki Lyons, M.D. / Kay Walker M.D.
McKay Dee Hospital
4403 Harrison Blvd Ste 4640
PH: 801-387-4850
FAX: 801-387-4855

Timothy J. Sullivan, M.D.
425 E 5350 S Ste 110
Washington Terrace, UT 84405
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AMERICAN COLLEGE OF ALLERGY AND IMMUNOLOGY | AMERICAN ACADEMY OF ALLERGY AND IMMUNOLOGY | AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY | AMERICAN BOARD OF INTERNAL MEDICINE

PATIENT:_____ APPT WITH: _____ APPT DATE:_____ TIME: _____

THE FOLLOWING INFORMATION IS PROVIDED TO HELP MAKE YOUR TIME SPENT IN THE DOCTOR'S OFFICE AS COMFORTABLE AS POSSIBLE. **IT IS VERY IMPORTANT TO FOLLOW THE DIRECTIONS LISTED BELOW**. IF YOU ARE NOT PREPPED PROPERLY FOR YOUR APPOINTMENT, WE WILL BE UNABLE TO PERFORM RELIABE TESTS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE.

- **ALL ANTIHISTAMINES MUST BE STOPPED 7 DAYS PRIOR TO YOUR APPOINTMENT.**
- **ALL EYE DROPS MUST BE STOPPED 7 DAYS PRIOR TO YOUR APPOINTMENT.**
- **ASTELIN NASAL SPRAY MUST BE STOPPED 7 DAYS PRIOR TO YOUR APPOINTMENT. OTHER NASAL SPRAYS MAY USED.**
- **BENADRYL MAY BE USED, BUT MUST BE STOPPED 24 HOURS PRIOR TO YOUR APPOINTMENT.**
- **IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICATIONS, THEY NEED TO BE STOPPED 7 DAYS PRIOR TO YOUR APPOINTMENT: IMIPRAMINE (TOFRANIL) *AMITRIPTYLINE (ELAVIL) *AMOXAPRINE *DESIPRAMINE * DOXEPIN (SINEQUAN) *NORTRIPTYLINE (PAMELOR) *PROTRIPTYLINE *TYLENOL PM *TYLENOL COLD *SLEEPING PILLS *ANY COLD OR NIGHT-TIME MEDICATION**

OUR ALLERGY EVALUATIONS MAY TAKE 2 HOURS OR LONGER, SO PLEASE MAKE SURE YOU ALLOW ADEQUATE TIME FOR YOUR APPOINTMENT. PLEASE REMEMBER TO BRING YOUR INSURANCE CARD, CO-PAY, AND THIS PACKET COMPLETELY FILLED OUT. IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE GIVE OUR OFFICE 24-48 HOURS' NOTICE. PER OUR POLICY, IF YOU DO NOT SHOW UP FOR YOUR SCHEDULED APPOINTMENT, OR CANCEL LESS THAN 24 HOURS BEFORE YOUR APPOINTMENT TIME, YOU WILL INCURE A $25.00 FEE.

THANK YOU FOR CHOOSING ADVANCED ALLERGY AND ASTHMA!

ADVANCED ALLERGY & ASTHMA

FAMILY REGISTRATION RECORD

4403 HARRISON BLVD
SUITE 4640
OGDEN, UT 84403
PHONE: (801) 387-4850 FAX: (801) 387-4855

VICKI J. LYONS, M.D., P.C.
TIMOTHY J. SULLIVAN, M.D., P.C.

PATIENT

LEGAL NAME: FIRST	M.I.	LAST NAME	SEX	DATE OF BIRTH	NICKNAME

MAILING ADDRESS	CITY	STATE	ZIP CODE	PRIMARY CARE PHYSICIAN
PHYSICAL ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE	

PRIMARY PHONE #	SECONDARY PHONE #	EMPLOYER	WORK PHONE #
EMAIL ADDRESS		OCCUPATION	PREFERRED PHARMACY

RACE

__ White
__ Hispanic/Latino
__ PATIENT DECLINE
__ American Indian/Alaskin Native
__ Native Hawaiian/Pacific Islander
__ Black/African American

ETHNICITY

__ Hispanic/Latino
__ NOT Hispanic/Latino
__ PATIENT DECLINE

MARITAL STATUS

__ Never Married
__ Domestic Partner
__ Separated
__ Married
__ Widowed
__ Divorced

SOCIAL SECURITY #

PREFERRED LANGUAGE

RESPONSIBLE PARTY IF OTHER THAN PATIENT

LEGAL NAME: FIRST	M.I.	LAST NAME	NICKNAME	SEX	DATE OF BIRTH

PRIMARY PHONE #	SECONDARY PHONE #	RELATIONSHIP TO PATIENT
EMPLOYER	WORK PHONE #	EMAIL ADDRESS	GUARANTOR SOCIAL SECURITY #
MAILING ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP CODE
PHYSICAL ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP CODE

SPOUSE/PARENT OR GUARDIAN

LEGAL NAME: FIRST	M.I.	LAST NAME	NICKNAME	SEX	DATE OF BIRTH

EMPLOYER	WORK PHONE #	EMAIL ADDRESS
PRIMARY PHONE #	SECONDARY PHONE #	RELATIONSHIP TOPATIENT
MAILING ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP CODE

EMERGENCY CONTACT (NEAREST RELATIVE NOT LIVING WITH YOU)

FIRST NAME	M.I.	LAST NAME	RELATIONSHIP TO PATIENT
PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
PRIMARY PHONE #	SECONDARY PHONE #	EMAIL ADDRESS

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	GROUP #	ID #	INSURED PARTY

INSURED'S DOB	INSURED'S SSN	INSURED'S EMPLOYER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COMPANY	GROUP #	ID #	INSURED PARTY

INSURED'S DOB	INSURED'S SSN	INSURED'S EMPLOYER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

COPAY DUE AT TIME OF SERVICE

FINANCIAL AGREEMENT

WHEN COLLECTION EFFORTS OVER AND ABOVE THE NORMAL BILLING ARE REQUIRED, AN ADDITIONAL SERVICE CHARGE MAY BE ASSESSED. AN ADDITIONAL CHARGE WILL BE ASSESSED FOR ALL CHECKS RETURNED FOR INSUFFICIENT FUNDS. THE OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF INSURANCE, OR OTHER CLAIMS. YOU ARE RESPONSIBLE FOR PAYMENT ON YOUR ACCOUNT IN ACCORDANCE WITH OUR POLICY. WE ANTICIPATE PAYMENTS ON YOUR ACCOUNT EVEN THOUGH YOU MAY HAVE AN INSURANCE CLAIM PENDING.

IN CONSIDERATION FOR MEDICAL SERVICES RENDERED, I (WE) HAVE RECEIVED WRITTEN NOTICE OF DR. VICKI LYONS' OR DR. TIMOTHY SULLIVAN'S ACCOUNT TERMS AND AGREE TO MAKE PAYMENT FOR SAID MEDICAL SERVICES ACCORDING TO SUCH TERMS. IT IS UNDERSTOOD AND AGREED THAT IF PAYMENT ON THIS ACCOUNT IS NOT MADE IN ACCORDANCE WITH THE TERMS OF THIS POLICY, I (WE) WILL PAY REASONABLE ATTORNEY'S FEES, COURT COSTS, AND/OR CHARGES OR COMMISSIONS THAT MAY BE ASSESSED BY ANY COLLECTION AGENCY RETAINED TO PURSUE THE COLLECTION OF THIS ACCOUNT. I (WE) AGREE TO PAY UP TO 40% OF COLLECTION EXPENSES INCURRED BY DR. VICKI LYONS OR DR. TIMOTHY SULLIVAN IN ATTEMPTING TO COLLECT SUCH AMOUNTS IN ADDITION TO THE AFOREMENTIONED ATTORNEY'S FEES AND COSTS. RECEIPT OF THIS POLICY STATEMENT IS NOTICE OF THE OFFICE'S ACCOUNT TERMS.

RELEASE OF INFORMATION

YOUR SIGNATURE AUTHORIZES DR. VICKI LYONS OR DR. TIMOTHY SULLIVAN TO RELEASE MEDICAL INFORMATION THAT MAY BE NECESSARY TO REQUEST CLAIM REIMBURSEMENT FROM INSURANCE COMPANIES OR OTHER PAYERS TO WHOM CLAIMS HAVE BEEN SUBMITTED AND TO RELEASE CREDIT INFORMATION GATHERING AGENCIES.

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. VICKI LYONS, DR. TIMOTHY SULLIVAN, OR THEIR AGENTS. YOUR SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THE CLAIM. IN THE CASE OF A MEDICARE CLAIM, THE PATIENT'S SIGNATURE AUTHORIZES ANY ENTITY TO RELEASE TO MEDICARE MEDICAL AND NON MEDICAL INFORMATION, INCLUDING EMPLOYMENT STATUS AND WHETHER THE PERSON HAS EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKER'S COMPENSATION OR OTHER INSURANCE WHICH IS RESPONSIBLE TO PAY FOR THE SERVICES FOR WHICH THE MEDICARE CLAIM IS MADE.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

ADVANCED ALLERGY & ASTHMA
QUESTIONAIRE

Vicki J. Lyons, M.D., P.C.
Timothy J. Sullivan, M.D., P.C.

PATIENT NAME: _____ DATE: _____

Please describe typical symptoms in your own words: _____

_____

Symptoms (Check all that apply):

Ears	Nose	Throat	Eyes	Skin	Constitution	Respiratory	Cardio	Gastro.	M/S	Other
Hearing Loss ☐	Congestion ☐	Hoarseness ☐	Itching ☐	Hives ☐	Fatigue ☐	Asthma ☐	Chest Pain ☐	Diarrhea ☐	Muscle Aches ☐	Headaches ☐
Ear Aches ☐	Sneezing ☐	Voice Loss ☐	Tearing ☐	Itching ☐	Loss of Appetite ☐	Cough ☐	Murmurs ☐	Vomiting ☐		Depression ☐
Discharge ☐	Nasal Disch ☐	Soreness ☐	Redness ☐	Irritated ☐	Weight Loss ☐	Wheezing ☐	Tightness ☐	Nausea ☐	Muscle Pains ☐	Anxiety ☐
Bleeding ☐	Bleeding ☐	Bad Breath ☐	Blurred ☐	Rash ☐	Abnormal Weight Gain ☐	Excessive Mucus ☐		Abdominal Pain ☐	Muscle Weakness ☐	Mood Swings ☐
Blockage ☐	Postnasal Drip ☐	Dryness ☐	Swelling ☐	Infections ☐	Fever/Chills ☐	Chest Tightness ☐		Bloating ☐	Arthritis ☐	
Itchy ☐	Itchy ☐	Itchy ☐	Styes ☐			Shortness of Breath ☐				
Frequent Inf. ☐	Loss of Smell ☐	Frequent Inf. ☐	Mattering ☐			Infections ☐				

All other ROS were reviewed and were found to be negative (Filled out by Doctor): _____

Are your symptoms: Year-Round ☐ Seasonal ☐ If seasonal: Worst Month: _____ Best Month: _____

How long have you had these problems? _____

Have you taken medication(s) to help your symptoms? YES ☐ NO ☐ Have they helped? YES ☐ NO ☐

List all medication you have tried: _____

Please list ALL medication you are taking, also list any vitamins or supplements:

DRUG	DOSE	FREQUENCY	DRUG	DOSE	FREQUENCY

Our office sends prescriptions electronically; list your preferred Pharmacy (Name & City): _____

I authorize and request a summary report of this visit to be sent to:

Referring Physician: _____ Address: _____

Referring Physician: _____ Address: _____

(If your referring physician is not listed we will not send a report.)

Medication Allergies: Do you have any drug or medication allergies? YES ☐ NO ☐

If yes, list drug(s), reaction(s) they caused, and date(s) reactions occurred: _____

_____

Food Allergies: Do you have any food allergies? YES ☐ NO ☐

If yes, list food(s) that have caused problems now and/or in the past: _____

_____

Venom: Have you ever had a **severe** reaction to a Bee, Wasp, or Hornet sting? YES ☐ NO ☐

If yes, describe the symptoms: _____

_____

Miscellaneous: Have you ever had (Check all that apply):

Tuberculosis Ulcers ☐ Diabetes ☐ Glaucoma ☐ High Blood Pressure ☐ Urinary Retention ☐ Cataracts ☐

Other Diseases: _____

Date of last Flu shot: _____

Do any of the following appear to be a cause of your allergy symptoms (check all that apply)?

Animal Dander: Cats☐ Dogs☐ Cattle☐ Horses☐ Other (specify): _____

Odors: Christmas Tree☐ Detergent☐ Soap☐ Hair Spray☐ Paint Fumes☐ Tobacco Smoke☐ Cosmetics/ Perfumes☐ Other (specify): _____

Pollen: Trees☐ Grass☐ Weeds☐ Other (specify): _____

Miscellaneous: Temp. Changes☐ Air Conditioning☐ Exertion☐ Excitement☐ Tension (Anxiety)☐ Windy Days☐
Fatigue☐ Infections☐ Laughing☐ Dampness☐ Menses (Periods)☐ Aspirin☐

Work Exposure: (Fumes or Odors) Name the chemicals: _____

Have you missed School or Work due to your allergies? YES☐NO☐ Approximately how much? _____

Hospitalizations/Operations:

Date	Procedure or Reason for Hospitalization
_____	_____
_____	_____
_____	_____

Home Environment: Age of Home: _____ Years at this Address: _____

Type of Construction (Check all that apply): Brick☐ Stone☐ Stucco☐ Wood☐ Prefabrication☐

Are Pets in the home? YES☐ NO☐ If yes, how many? Dogs:___Cats: ___ Birds: ____ Horses: _____ Other (Specify): _____
Are there feather pillows? YES☐NO☐ If yes, please list the location: _____

Is the basement wet?YES☐NO☐ Do you smell mildew in the house? Y☐ N☐

Heating Systems: (Circle ALL that apply)
Type of heating system in the house: Coal☐ Gas☐ Oil☐ Electric☐ Other (Specify): _____
Do you use furnace filters? YES☐ NO☐
Do you have Air Conditioning?YES☐NO☐ If yes, which type? Do use electronic air cleaners or purifiers?☐YES ☐NO Central Air☐ SwampCooler☐Other (Specify): _____

Miscellaneous:

Has a change in your locale affected your symptoms (i.e. new home, new job, etc.)? YES☐/ NO☐
If yes, please explain the change & symptoms: _____

Does your Neighborhood contain the following (check all that apply)? Trees☐Fields☐ Farms☐Other (specify): _____

Previous Allergy Studies:

Have you had skin tests done in the past? YES☐NO☐ Doctor: _____ Date: _____
Test Results: _____
Did you receive Allergy Shots? YES☐/ NO☐

Health Habits:

Do you smoke Tobacco? (Check ONE) Current Smoker☐ Former Smoker☐ Never Smoked☐ If a current smoker: How many years? _____ How many packs a day? ____

Do others smoke in your home? YES☐/ NO☐

Family History:

Have any of your *Immediate* family members seen a provider at Advanced Allergy & Asthma? YES☐/ NO☐
If yes, please list the Name & Relationship to you (i.e. mom, dad, brother, etc.): _____

If you know of allergies in any of your relatives, please place an X in the corresponding table below:

Allergy Condition	Sister(s)	Brother(s)	Mother	Father	Grandma Specify: paternal/ maternal	Grandpa Specify: paternal/ maternal	Uncle Specify: paternal/ maternal	Aunt Specify: paternal/ maternal
Hay Fever/Other Nasal Allergy								
Asthma								
Eczema								
Hives								

Is there a family history of any other disease(s) or condition(s)? Please list family member's relationship & disease/condition:

_____

_____

VICKI J. LYONS, M.D., P.C.
TIMOTHY J. SULLIVAN, M.D., P.C.

ADVANCED ALLERGY & ASTHMA

Consent and Conditions of Treatment

As either the Patient or the legally authorized representative of the Patient, the following consents, understandings, and agreement are made on my own behalf of the Patient in partial consideration of the health care services to be provided to the Patient in this Advanced Allergy & Asthma, LLC facility ("Facility"):

1. **Consent for Services.** On behalf of the Patient, consent is hereby given to the Facility, its independent contractors (see 2.b, below), medical staff, and employees to provide health care services to the Patient, to administer physician orders for the benefit of the Patient, and to provide all related care and services to the Patient while in the Facility, including but not limited to all routine and non-routine tests and studies ordered in the belief that they are medically necessary or appropriate for the Patient. See also, 2.a, below. It is understood that Facility services, medical care, and surgery are not exact sciences and that there is a risk of substantial and serious harm involved in such services, and such risk is accepted in the hope of obtaining beneficial results from such services. It is understood that the Patient and his/her legally authorized representatives have the right to ask questions and to receive answers to such questions about the Patient's condition and the health care services. At this time, all such questions, if any, have been satisfactorily answered. No promises of any particular outcome or successful results have been made, it being understood and accepted that there is some uncertainty involved in the Facility and health care services for which consent is given.

2. **Miscellaneous Agreements and Understandings:**
   - **a. Medical Education.** Permission is given for persons involved in medical education to be present and/or participate when the Patient receives health care services. Student will be directly supervised by the Physician or staff employees from whom they are receiving training or education.
   - **b. Independent Contractors.** It is understood that many physicians and other health care providers furnishing services to the Patient, including residents and interns, are independent contractors or medical students and are not agents or employees of the Facility.
   - **c. Personal Property.** It is understood that the Facility is not responsible for personal property.
   - **d. Release of Information.** The law requires the Facility to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and the information they contain only in accordance with State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice of Privacy Practices, which are emended from time to time.
   - **e. Assignment of Benefits.** Any and all benefits from insurance companies and other third party payers that are payable to the Patient or on behalf of the Patient for health care services, and all related payments for services rendered or provided to the Patient in the Facility are hereby transferred and assigned to the Facility for the exclusive purpose of obtaining payment for charges associated with health care services provided to the Patient in the Facility. It is understood and agreed that all insurance companies and other third party payers will pay benefits directly to the Facility in payment of the Facility's charges.
   - **f. Financial Responsibility.** Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all health care services rendered to the Patient in the Facility including, but not limited to any amounts not paid by any insurance company or other third party payer. It is understood that the Patient and the undersigned are also responsible to pay all applicable co-payments, deductibles, co-insurance, and all charges for non-covered services. It is understood and agreed that charges not paid in a timely fashion will be placed for collection with a collection agency or attorney. At that point the Patient and the undersigned each jointly and severally agree to pay costs and a reasonable attorney's fee in connection with the collection process, a 40% collection expense incurred by the Facility in attempting to collect such amounts in addition to the attorney's fees and costs will be assessed. A $20 service charge will be assessed for any returned checks or other tender not payable.

OVER → → →

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Ogden, UT 84403
Phone: 801-387-4850 Fax: 801-387-4855

VICKI J. LYONS, M.D., P.C.
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g. **Patient's Certification for Government Health Care Programs.** I certify that the information given in applying for payment for Medicare, Medicaid, Champus, Tricare, or any other government program for payment under Titles XVIII and XIX of Social Security Act or otherwise, is correct. I authorize any holder of medical or other information about me to release to the Tricare administrator, Social Security Administration or its intermediaries, or other carriers or program administrators, or to the State or any other payer, any information needed to substantiate and process a claim for payment for this or any related service. I request that payment of authorized charges be made on my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its services.

h. **Consent for Photographs.** It is understood that in the interest of preserving accurate allergy, identification, and other related testing, it may be necessary to obtain facial, profile, and testing site photographs. Such photographs will become part of the Patient's medical record. These photographs will be safeguarded as described in 2.d, above. The photographs are expressly used for facilitating concurrent medical treatment and interpretation reference.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding of what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balance due, lab results available, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

Beginning April 14, 2003; the following provision applies: I hereby acknowledge that I have received or been offered a copy of Advance Allergy & Asthma's Notice of Privacy Practices.

Patient's Name (Printed)	**X** _____ **Patient's or Representative's Signature**
Date Signed	**Representative's Name (Printed)**
X _____ **Staff Member Witness**	**Relationship to Patient**

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ADVANCED ALLERGY & ASTHMA
Notice of Privacy Practices

The federal government recently published regulations designed to protect the privacy of your medical information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans. Physicians have until April 14, 2003 to comply with the privacy rule's standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan; your physician, hospital, or other health care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We also take precautions in our office to safeguard your health information such as training our employees and employing computer security measures. Please feel free to ask our Privacy Officer about exercising your rights or how your health information is protected in our office.

The following Notice of Privacy Practices explains our privacy practices. It contains very important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our Privacy Office at 801-387-4850 to discuss any questions you may have.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This policy also describes how we may use other information about you.

Please review it carefully.

I. Who We Are

This Notice describes the privacy practices of Advanced Allergy & Asthma, its employees (including providers, nurses, and technicians), and other individuals who work with Advanced Allergy & Asthma. It also refers to clinics, provider offices, and other facilities.

II. Our Privacy Obligations

Certain laws require Advanced Allergy & Asthma to maintain the privacy of medical and health information about you ("Protected Health Information") and to provide you with the Notice of our legal duties and privacy practices with respect to Protected Health Information. When we use or disclose Protected Health Information, we are required to abide by the terms of this Notice (or another notice in effect at the time of the use or disclosure).

III. Uses and Disclosures with Your Consent or Your Authorization

A. Use and Disclosure With Your Consent. As a condition of treatment, except in an emergency or other special circumstances, we will ask you to read and sign a written consent ("Your Consent") to our use and disclosure of Protected Health Information for purposes of treatment provided to you, obtaining payment for services provided to you, and for our health care operations (e.g. internal administration, quality improvement, and customer service), as detailed below:

- Treatment. We use and disclose Protected Health Information to provide treatment and other services to you – for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Payment. We may use and disclose Protected Health Information to obtain payment for services that we provide to you – for example, we may use or disclose Protected Health Information to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payer"), and to verify that Your Payer will pay for health care.
- Health Care Operations. We use and disclose Protected Health Information for our health care operations, which include internal administration and planning and various activities that improve the quality and cost-effectiveness of the care that we deliver to you. These services may also include our business planning, providing customer services, and conducting quality assessment and improvement activities.

B. Use or Disclosure with Your Authorization. As described above, Your Consent only permits us to use Protected Health Information for purposes of treatment, payment, and our health care operations. We may use or disclose Protected Health Information for any reason other than treatment, payment, and health care operations only when (1) you give us your authorization on our authorization form ("Your Authorization") or (2) there is an exception described in Section IV below.

IV. Uses and Disclosures Without Your Consent or Your Authorization

Use or Disclosure For Treatment, Payment, and Health Care Operations Without Your Consent or Your Authorization. Advanced Allergy & Asthma, may use or disclose Protected Health Information for purposes of treatment, obtaining payment, and our health care operations without Your Consent or Your Authorization under the following three circumstances: (1) when you require emergency treatment; (2) when we are required by law to treat you and we attempted to obtain Your Consent, but we are unable to obtain it; and (3) when we attempt to obtain Your Consent but are unable to obtain it due to substantial barriers to communicating with you (e.g. you are unconscious or otherwise incapacitated) and we reasonably infer that you would have consented in the absence of the barriers.

Disclosure to Relatives and Close Friends. When you are present in an Advanced Allergy & Asthma facility and are capable of communicating, we may use or disclose Protected Health Information to a family member, other relative, a close personal friend, or to any other person identified by you if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative, or a close personal friend; we would disclose only information that is directly relevant to the person's involvement with your health care.

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VICKI J. LYONS, M.D., P.C.
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Marketing Communications. We may use or disclose Protected Health Information to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

Public Health Activities. We may disclose Protected Health Information for the following public health activities and purposes: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability, as required by law and public health concerns; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to received such reports, (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable diseased or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect, or Domestic Violence. We may disclose Protected Health Information without Your Consent or Authorization to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if we reasonably believe your are a victim of abuse, neglect, or domestic violence.

Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency that oversees the health care system and ensures compliance with the rules of government health programs such as Medicare and Medicaid.

Judicial and Administrative Proceedings. We may disclose Protected Health Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. We may disclose Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order.

Health or Safety. We may disclose Protected Health Information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Specialized Government Functions. We may disclose Protected Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State.

Decedents. We may disclose Protected Health Information to a coroner or medical examiner as authorized by law.

Clinical Studies. We may disclose Protected Health Information without Your Consent or Authorization for purposes such as those preparatory to research and the creation of a research database. If deemed necessary by our Research Manager or the Privacy Officer, we may require approval of a waiver of authorization for disclosure to be reviewed by the IRB (Institutional Review Board) associated with the study.

Workers' Compensation. We may disclose Protected Health Information as necessary to comply with workers' compensation laws.

V. Your Individual Rights

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to Protected Health Information you may contact our Privacy Office. You may also file written complaints with the Director of the Office of Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with the Director or us.

As a patient, you have the right to:

Request Additional Restrictions. You may request restrictions on our use and disclosure of Protected Health Information (1) for treatment, payment, and health care operations; (2) to individuals (such as family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care; or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

Receive Confidential Communications. You may request, and we will accommodate any reasonable written request, for you to receive Protected Health Information by alternative means of communication or at alternative locations.

Inspect and Copy Your Health Information. You may request access to your medical record file, as well as your payment, claims adjudication, case, medical management records, and your 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 request a copy or copies of your record, you will be charged a cost-based fee for each copy.

Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file, payment, claims adjudication, case, medical management records, or billing records. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

Receive Paper Copy of This Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

Effective Date. This Notice describes the privacy policy of Advanced Allergy & Asthma that went into effective on or before April 14, 2003; the date that federal law specifies for these protections of Protected Health Information. Prior to the effective date, Advanced Allergy & Asthma protected your Protected Health Information as required by other applicable laws, regulations, and policies.

Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the notice in waiting areas. You may also obtain any new Notice by contacting the Privacy Office.

VII. Privacy Office

You may contact the Privacy Office at:

Advanced Allergy & Asthma
Vicki J. Lyons, M.D.
Timothy J. Sullivan, M.D.
4403 Harrison Blvd., Suite 4640
Ogden, UT 84403
Phone: 801-387-4850 Fax: 801-387-4855

McKay Dee Hospital
4403 Harrison Blvd., STE 4640
Ogden, UT 84403
Phone: 801-387-4850 Fax: 801-387-4855

VICKI J. LYONS, M.D., P.C.
TIMOTHY J. SULLIVAN, M.D., P.C.

ADVANCED ALLERGY & ASTHMA

Payment Agreement & Payment Policy Acknowledgement

We appreciate your business and strive to maintain the highest quality of care possible while controlling health care costs. Please be aware of the following prior to your visit.

If you have NO insurance or your insurance does not pay for allergy testing/treatment:

1. Our average office visit/allergy testing is estimated at $400 to $1500 for all patients; however, this is just an estimate. We require an initial payment due at the time of service of $151.20 for new patients and $85.00 for established patients. Actual charges cannot be determined until you see the provider, and charges are added to your account. You will receive a discount on your office visit and/or testing if paid in full at the time of service. If you have a more extensive exam than normal, lab work, radiology tests, or any other medical care you will incur additional charges (which may involve other medical entities). If you are interested in getting the discount, please discuss this with the receptionist or billing office.
2. Please be aware that it is impossible to get an exact estimate of your charges prior to your exam. Therefore, it may become necessary to bill you for any additional balances. If you receive a statement from us, payment is due 15 days from the date of your statement. We may use outside billing services to assist us in collection of this account, which may include payment plans or other means to collect the debt.
3. The patient and/or their guarantor will be responsible for any and all collection costs of 40%, attorney's fees, and court fees if Vicki J. Lyons, M.D., Dr. Timothy J. Sullivan, M.D., and/or billing office representing either doctor are unable to efficiently collect on charges that you incur.

If you have insurance that covers allergy testing/treatment:

1. Vicki J. Lyons, M.D. or Timothy J. Sullivan, M.D. will submit the charges to your insurance companies as a courtesy to you if:
   a) You bring a current insurance card with you to each visit, or have current card copy on file.
   b) You pay any required co-payment at the time of service.
2. Your insurance company may require a co-payment from you. Your contract requires this to be paid at the time of service; failure to do so may result in rescheduling of your appointment. Your co-payment may not be your only liability. If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you may be responsible for payment of the services. If you receive a statement from us, payment is due 15 days from the statement date. We may use outside billing services to assist us in collections of this account, which may include payment plans or other means to collect the debt.
3. If your insurance plan requires a referral to authorize this visit, we require that you bring a written referral from your primary care physician or verification that the referral has been called in to your insurance company. If you do not have the referral when you come, payment for the visit becomes your responsibility until the referral is provided to one of our providers or our office staff.
4. It is the patient's and/or their guarantor's responsibility to know the provisions of their insurance policies, their preferred facility and locations where services are covered. It is ultimately the patient's and/or guarantor's responsibility to ensure that services billed on their behalf by one of our providers are paid timely and accurately, either from the insurance and/or other responsible parties.
5. Some insurance companies do not cover Allergy and Immunology services. If you insurance does not cover these services, please be aware that you will be required to pay any denied services.
6. The patient and/or their guarantor will be responsible for any and all collections costs of 40%, attorney's fees, and court fees if one of our providers and/or billing office representing one of our providers are unable to efficiently collect on charges that you incur.

Medicaid Patients:

1. You are required to present your Medicaid Card at each visit. If you fail to show your card, and services are denied, you will be responsible for payment.
2. All Medicaid co-payments are due at the time of service; failure to do so may result in rescheduling of your appointment.
3. You will be held responsible for payment of any charges that are denied as "Not a Medical Benefit." You will also be held responsible for payment of any charges if one of our providers is not contracted with your Medicaid HMO (i.e. PCN Medicaid).

If you have any questions please feel free to contact our office at 801-387-4850.

I have read and understand all of the above information. I agree to pay for all charges incurred including any collection costs of 40%, attorney's fees, and court fees as described above.

May08

Patient/Guarantor Signature _____ *Date* _____

Account # _____ *Witness* _____

ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. You can pursue your Claim and seek damages, but you are waiving your right to have it decided but a judge or jury.

Article 2 Definitions

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3 (15)). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group, or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:
(1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND
(2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
- (1) Working directly with each other to try and find a solution that resolves the Claim, OR
- (2) using non-binding mediation (each of us will bear one-half of the costs); OR
- (3) using binding arbitration as described in this Agreement.

You may choose to use any or all of these methods to resolve your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration- Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice. To make Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statue of limitations during the dispute resolution process described in this Agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.

(1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint and arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. You and the Provider(s) will them jointly appoint an arbitrator (the "Jointly-Selected Arbitrator") If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual the lists described above. Each party will pay their own fees and costs in such an action. The Jointly Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in Utah Uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each will also pay on-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May be Arbitrated Separately
At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue/ Governing Law
The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre-litigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term/ Rescission / Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this Agreement with 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the recession notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provide care prior to the signing of this agreement. (see Article 4 (E)).
Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability
If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration
I have received a written explanation of the terms of this Agreement. I have h ad the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard but a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility of arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy I have received a copy of this document.

Provider

Allergy Asthma & Asthma

Name of Physician, Group or Clinic	Name of Patient (Print)
By: Vicki J. Lyons, M. D. / Timothy J. Sullivan, M.D.	
Signature of Physician or Authorized Agent	Signature of Patient or Patient's Representative (Date)

(05/03/14)