

# CINCINNATI ALLERGY AND ASTHMA CENTER, INC.

**Ann C. Ghory, M. D.**

**Patricia K. Ghory, M.D.**

## PATIENT INFORMATION BOOKLET

### INTRODUCTION

An allergy consultant is a physician who specializes in hypersensitivity diseases, such as hay fever, sinusitis, asthma, food allergies, eczema, hives, and bee stings. Your primary care physician has referred you to us for consultation and evaluation of your symptoms. Your initial consultation will take approximately one hour and will consist of a complete history and examination, plus pulmonary function tests and hearing tests if required. At this time, it will be determined whether further evaluation through skin testing is warranted and will be performed the same day if needed.

If, after testing, an allergy desensitization program is recommended, an allergy extract will be prepared for your individual needs. After 3 years on immunotherapy – we will retest you at this time.

Our services are provided on an out-patient basis only. If for any reason, it becomes necessary for you to be admitted into a hospital, your primary care physician will be the admitting doctor.

### APPOINTMENTS

The office hours vary each day, so please check with our receptionist. We ask for your patience if there is a delay in our schedule due to emergencies. A conscientious effort is made to stay on schedule. **Emergencies** are given our immediate attention. If you are unable to keep your appointment, please call the office at least 24 hours in advance. If late for your appointment, rescheduling may occur due to our busy schedule. These courtesies allow us to be of service to all patients.

If someone other than the parent comes with a minor to his/her appointment, a note must accompany that individual stating that we release information to him/her.

### CONFIDENTIALITY

Your medical records are strictly private. Information will be released only upon written request of the patient or parent. These forms are available at each of our locations.

### TELEPHONE CALLS

Please feel free to call the office if you have any questions regarding your allergy problem. Please give the doctor's assistant a complete message concerning your problem. They are trained to answer your questions and if it is necessary for the doctor to return your call, she will call you as soon as conditions permit.

### INSURANCE

Insurance claims will automatically be filed by our billing department upon receipt of complete insurance information. Although we will assist in every way possible with insurance claims, the patient is ultimately responsible for payment. For insurance and/or billing questions, call: (513) 624-1902.

### INSTRUCTIONS FOR CONSULTATION

1. Complete the forms prior to coming to our office for your appointment.
2. Bring your **valid driver license** and insurance card. We will need to copy both for your chart.
3. Arrive at our office 20 minutes before your scheduled appointment.
4. Allow a minimum of one to two hours for the initial visit.
5. **If your insurance requires that you have a referral form or prior authorization, make sure this has been received at our office before your visit. All co-pays are due at the time of service.**

**Any questions, please contact our office.  
(513) 861-0222**

**Anderson:**  
7495 State Road #350, Cinti, OH 45255

**Mason:**  
9313 Mason-Montgomery Rd, Mason, OH 45040

**Hyde Park:**  
2727 Madison Rd #300, Cinti, OH 45209

**Western Hills:**  
6350 Glenway Ave #200, Cinti, OH 45211

**CINCINNATI ALLERGY AND ASTHMA CENTER, INC.**

**Patient Registration Form**

**Appointment Date/ Time/ Doctor / Location:** \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
(Last) (First) (Middle)

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone:( ) \_\_\_\_\_ Cell Phone:( ) \_\_\_\_\_ Work Phone:( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Marital Status:  Single  Married - Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Daytime Ph. # \_\_\_\_\_  
 Separated/Divorced  Widowed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician (s) who care (s) for you and to whom we may disclose information regarding your care \_\_\_\_\_  
Phone \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

If patient is a minor, please provide parental information:

Mother's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Emp. Address: \_\_\_\_\_ Daytime Ph. #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Emp. Address: \_\_\_\_\_ Daytime Ph. #: \_\_\_\_\_ Occupation: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

ID# \_\_\_\_\_ DOB \_\_\_\_\_

Group Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

ID# \_\_\_\_\_ DOB \_\_\_\_\_

Group Policy #: \_\_\_\_\_

**INSURED CARDHOLDER OR OTHER FINANCIALLY RESPONSIBLE PARTY ( if patient-simply write "Patient" , if parent, simply write "Mother", "Father", in the space provided for "Name" and complete "\*\*", otherwise fill out completely).**

I, \_\_\_\_\_ (Print Name), will assume all financial responsibilities.

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone:( ) \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

\*Relationship to insured/ patient: \_\_\_\_\_

(Husband/Wife/Son/Daughter/Self)

**\*Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The parent or guardian authorizing treatment, then you are the person financially responsible for any uncovered expenses.

**STAFF USE ONLY**

- Have patient sign below yearly ONLY IF NO CHANGE with information above

**\*Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The parent or guardian authorizing treatment, then you are the person financially responsible for any uncovered expenses.

**\*Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The parent or guardian authorizing treatment, then you are the person financially responsible for any uncovered expenses.

Patient Name: \_\_\_\_\_  
Please Print

DOB \_\_\_\_\_

# Cincinnati Allergy & Asthma Center

## PAYMENT AGREEMENT

**Regardless of insurance benefits, or the designation of some other responsible party on the registration form, I understand that I am financially responsible for the fees. I understand I am responsible to know if I am covered by my insurance and if CAAC is a provider.** If I am covered by Medicare, I understand that if I am provided specific written notice in advance that Medicare is not likely to cover a particular visit or procedure, I will be responsible for payment of that procedure or visit if I agree to proceed. Although CAAC will take reasonable steps to obtain reimbursement from the insurance company or the persons listed on the registration form as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financially responsible party. Further, in the event of payment default, I agree to pay all collection costs in excess of the initial fee (including any legal expenses) and, at the option of CAAC, a reasonable charge for late payments.

**AT THE TIME OF THE VISIT,** I understand it is my responsibility to obtain a current referral (if required) and pay any **deductibles, co-payments, and/or coinsurance** not covered by the insurance plan or a government program. I understand that I will be billed **\$5** to cover invoicing cost for each visit for which I do not pay my portion at the time service is rendered. Further, I authorize CAAC to file claims on my behalf for covered services and assign all insurance or other payer benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original. For missed appointments, there is a **\$20** fee unless the appointment has been cancelled at least 24 hours in advance.

**I have read and I understand this document.**

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Please Print

DOB \_\_\_\_\_

**RELEASE OF INFORMATION**

**Practice Philosophy on Patient Privacy**

The Cincinnati Allergy & Asthma Center (here forward referred to as "CAAC") recognizes the importance of patient privacy. As such, it is the policy of the CAAC to treat all medical information as confidential and absent extraordinary or emergency circumstances; CAAC will not disclose a patient's medical information without appropriate patient consent.

Before consenting to the release of medical information, each patient has the right to review the written Notice of Privacy Policy of CAAC, which gives a more complete description of CAAC's policies on the use and disclosure of patients' medical information. Each patient may obtain a copy of such Notice upon request. CAAC reserves the right to change its Notice of Privacy Policy and all patients have the right to receive an amended copy of the Notice upon request.

Also, each patient has the right to request in writing that CAAC restrict how protected and private medical information is used or disclosed to carry out treatment, payment, or other health care operations. Please note that CAAC is not required to agree to such requested restrictions, but if it does, the restriction will be binding upon this practice. Additionally, CAAC may refuse to treat any patient who refuses to consent to the use and disclosure of medical information for treatment, payment, or other health care operations purposes.

**Patient Consent for Use and Disclosure of Medical Information To Carry Out Treatment, Payment, and Health Care Operations**

I consent to the release of information regarding services rendered by CAAC to my insurance company or any governmental payer of the medical expenses as listed above, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of all medical information (including - but not limiting - doctors notes, labs, pictures of ailments, etc) to my family physician and other treating physicians/laboratories, as listed by me above, as well as to any physicians to whom CAAC may refer me for purposes of further treatment/diagnosis. I consent to the use and/or release of medical information about me for purposes of health care operations, as it relates to CAAC's internal practices and general administrative activities. In addition, if the patient is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person (s) that I have listed above as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including, but not limited to, electronic mail ("email") and facsimile.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that CAAC has taken action in reliance upon my consent.

Patient/parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**ACKNOWLEDGEMENT**

I, \_\_\_\_\_ (patient, parent or legal guardian),  
acknowledge that I have received a copy of Cincinnati Allergy & Asthma Center's  
"Notice Regarding Privacy of Personal Information."

**DISCLOSURE TO FAMILY/FRIENDS**

I HEREBY AUTHORIZE CINCINNATI ALLERGY AND ASTHMA CENTER, INC. TO DISCUSS  
THE FOLLOWING WITH THE PERSON/PERSONS LISTED BELOW:

- YES / NO      CONDITION/TREATMENT/PLAN OF CARE
- YES / NO      DIAGNOSTIC/LAB TEST RESULTS
- YES / NO      PHOTOGRAPHS TAKEN IN OFFICE OF SKIN DISORDER/EYE SYMPTOMS/ETC.
- YES / NO      BILLING INQUIRIES
- YES / NO      PERMISSION TO LEAVE MESSAGES/TEST RESULTS ON  
VOICE MAIL/ANSWERING MACHINE

**ALLOWED PERSON/PERSONS:** (ie: spouse, step-parents, grandparents, etc):

<u>NAME</u>	<u>RELATION</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(\* NOTE IF PATIENT IS 18 YEARS OR OLDER THEY ARE CONSIDERED AN ADULT)

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

***This form is necessary for the Health Insurance Portability  
and Accountability Act enforced by the Federal Government.***

**NOTICE OF PRIVACY PRACTICES**

**Cincinnati Allergy & Asthma Center  
Dr. Ann Ghory / Dr. Patty Ghory**

HIPAA Officer: Michelle Algiers, Assistant Clinical Coordinator  
(513) 861-0222 Ext: 1211

**Effective Date: 09/23/13**

**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.**

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

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**A. How This Medical Practice May Use or Disclose Your Health Information**

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the
4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication With Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. **Marketing.** Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information.** We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities.** We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. **Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. **Proof of Immunization.** We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Workers' Compensation.** We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]
22. **Psychotherapy Notes.** We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. **Research.** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. **Fundraising.** We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

**B. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**C. Your Health Information Rights**

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. **Right to a Paper or Electronic Copy of this Notice.** You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

**D. Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

**E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

**Region V - Chicago (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)**  
Celeste Davis, Regional Manager  
Office for Civil Rights  
[OCRMail@hhs.gov](mailto:OCRMail@hhs.gov)

The complaint form may be found at: [www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf](http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf).

You will not be penalized in any way for filing a complaint.



# CINCINNATI ALLERGY & ASTHMA CENTER

Ann C. Ghory, M.D.

Patricia K. Ghory, M.D.

**ALLERGY SKIN TESTING** tells you if you are allergic to things that may be causing your symptoms.

There are two types of skin tests:

- a.) PRICK: A tiny prick is made with a special plastic toothpick” containing a small amount of “allergen.”
- b.) INTRADERMAL: A small amount of allergen is placed underneath the top layer of skin to form a bump the size of a small mosquito bite.

If you are allergic, a small red bump (that itches) will appear within 15-20 minutes. Delayed reactions to mites and molds may occur, and the reactions could appear that night or the next morning.

**RAST TESTING** is a less sensitive, and more expensive blood test that may show what things cause your allergy symptoms.

You must discontinue the following medications:

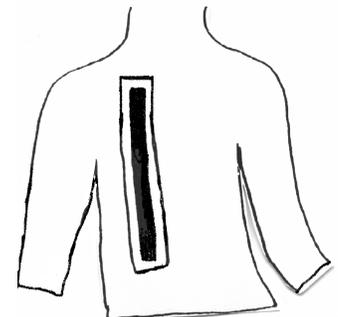
Days off:

ALLEGRA	7 days
ASTELIN / ASTEPRO NASAL	48 hours
CLARINEX	7 days
CLARITIN	7 days
ZYRTEC	7 days
XYZAL	7 days
LORATADINE	7 days
ALAVERT	7 days
PATANASE NASAL SPRAY	48 hours
ALL OTHER ANTIHISTAMINES including PYRILAMINE, BENADRYL/DIPHENHYDRAMINE, CHLORPHENIRAMINE, BROMPHENIRAMINE, ETC.	48 hours
ZANTAC, TAGAMET, AXID, and PEPCID	24 hours
BETA - BLOCKERS	Stop morning of testing
TYLENOL PM (Advil PM, ETC.)	48 hours
AMITRIPTYLINE (ELAVIL, TRYPTIZOL, LAROXYL, SAROTEX, LENTIZOL)	48 hours
TRICYCLIC (AMOXAPINE, DESPIRAMINE, NORPRAMIN, DOXEPIN, MAPROLMIPRAMINE, TOFRANIL, TOFRANIL-PM, TILINE NORTRIPTYLINE, PAMELOR, PROTRIPTYLINE, VIVACTIL, SURMONTIL)	48 hours

**\*\*You may continue to take all other medications, including antibiotics, decongestants, and nasal sprays.**

## PROCEDURE FOR APPLICATION OF ANESTHETIC PATCHES WHEN NEEDED

1. One hour prior to scheduled appointment - clean back with soap and water, then cleanse with alcohol preps. Allow to dry.
2. After removing the plastic covering apply, a generous amount of cream down the center and spread **EVENLY** over gauze strip.  
**(About half of the tube of cream should be used.)**
3. Apply anesthetic patch firmly to the back- at least one inch from the spine (See diagram).
4. If necessary, please add more tape to the back to secure the patch.
5. If you have any questions, please contact our office: All Offices: (513) 861-0222



**PLEASE ALLOW UP TO 2 HOURS FOR TESTING**

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