SAN TAN Allergy & Asthma

4915 E. Baseline Road Suite 112
Gilbert, AZ 85234
Ph (480) 626-6600 – Fax (480) 626-6604

S. Reed Shimamoto, MD ● David Reeder, MD ● Kerry Berghoff, FNP-C ● Corey Seguine, PA-C

Welcome to San Tan Allergy & Asthma!

Thank you for selecting San Tan Allergy & Asthma for your healthcare needs. Our dedicated team of providers and staff is committed to delivering exceptional care for a wide range of allergic and immune conditions. These include asthma, atopic dermatitis, food allergies, allergic rhinitis (hay fever), hives, angioedema, and immune deficiency syndromes. We pride ourselves on our patient-centered approach, which means we tailor our treatment plans to meet the unique needs of each individual. By employing evidence-based practices and utilizing cutting-edge technology, we strive to provide you with the highest quality care and support.

Preparing for Your Appointment

To ensure that your visit runs smoothly and efficiently, we kindly ask you to prepare by following these steps:

- **Time Commitment:** Please allocate approximately 1 to 2 hours for your appointment. This allows us to provide thorough care and address any questions or concerns you may have.
- **Paperwork:** To expedite your visit, complete your New Patient Paperwork before arriving at our office. This will help us process your information quickly and efficiently.
- **Medical Records:** Bring any relevant medical records from previous allergists or your referring physician. This will assist us in understanding your medical history and tailoring your treatment plan accordingly.
- **Identification:** For check-in purposes, please bring a copy of your insurance card and a photo ID. These documents are necessary to verify your identity and insurance coverage.

Patient Portal Access

We encourage you to utilize our secure, HIPAA-compliant patient portal, IMS Care (Clinic ID: P1357409), which is accessible online and through the Google Play Store and Apple App Store. The IMS Care portal offers a range of features designed to enhance your experience, including:

- **Updating Personal Information:** Easily update your contact details and other personal information.
- **Viewing and Downloading Records:** Access and download visit summaries, medical records, and securely send documents to your provider.
- **Managing Appointments:** Request, reschedule, or cancel appointments with ease.
- **Secure Messaging:** Communicate with your provider through secure messaging for any questions or concerns.
- **Insurance Information:** Review and manage your insurance details and coverage.
- **Medication Management:** View your current medications and request refills as needed.
- **Form Completion:** Complete necessary forms for your appointments from the comfort of your home.
- **Billing:** View your billing statement, check your payment history, and make payments online.

Office Location and Appointment Information

Our office is conveniently located in Gilbert, on the south side of Baseline Road (west of Safeway), west of Higley Road on Claiborne, within the Gateway Medical Professional Village. To ensure timely service, please arrive 15 minutes early for your appointment. If you are running late, we may need to reschedule your visit to avoid delays for other patients.

If you need to cancel your appointment, we request that you provide a 24 hours' notice. This allows us to offer the appointment slot to other patients in need of care.
Should you have any questions or need assistance before your visit, do not hesitate to contact us at 480-626-6600. We look forward to welcoming you to San Tan Allergy & Asthma and providing you with outstanding care.

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Financial Policy

To help you navigate our billing and payment procedures, we ask that you carefully review our financial policy for important information and clarity. By proceeding with your care, you acknowledge and agree that you are financially responsible for any charges not covered by your insurance. Additionally, you confirm that you have read, understood, and agree to comply with the San Tan Allergy & Asthma Financial Policy, accepting responsibility for all payments due as outlined in the policy.

1. Identification

- To ensure a smooth and efficient check-in process, please be advised that **all patients are required to present a valid insurance card and a photo ID at the time of their visit**. These documents are necessary for verifying your identity and insurance coverage, which helps us provide you with accurate and timely care. ***If you are 18 years of age or older you are considered the responsible party for all billing related matters at San Tan Allergy and Asthma.***

2. Insurance and Payment Responsibility

- **Insurance Coverage**: We accept a variety of insurance plans. It is your responsibility to verify that our office is an in-network provider for your insurance plan. If we are not in-network, you may be responsible for higher out-of-pocket costs.
- **Co-Payments and Deductibles**: Co-payments, co-insurance, and deductibles are due at the time of service. Please check with your insurance provider to understand your financial responsibilities before your visit.
- **Non-Covered Services**: Some services may not be covered by your insurance. If you have questions about whether a service is covered, please contact your insurance company directly or inquire with our billing department before your appointment.

3. Billing Procedures

- **Statements**: You will receive a statement if there is a balance due after your insurance has processed the claim. Statements are issued monthly.
- **Payment Methods**: We accept payments via cash, check, credit/debit card, and electronic payment methods. Please make checks payable to San Tan Allergy and Asthma. Please note that for cash payments, we do not provide change. Any excess cash payments will be applied as a credit to your account.
- **Payment Plans**: If you are unable to pay your balance in full, please contact our billing department to discuss payment plan options. Arrangements must be made in advance and are subject to approval.
- **Contact Information:** San Tan Allergy and Asthma collaborates with a third-party billing company, Dr. Catalyst, for managing billing services. If you have any questions about our financial policy or need assistance with billing and payments, please contact our billing department at 888-899-0074. Information provided by non-billing staff members should be verified with Dr. Catalyst.

4. Missed Appointments

- **No-Show Policy**: If you are unable to attend your scheduled appointment, please notify our office at least within 24 hours of your appointment time to allow us to offer the time slot to other patients. Failure to cancel in advance will result in a $50 missed appointment fee. Patients who miss two consecutive appointments must settle any outstanding fees before being rescheduled.

5. Refunds

- **Overpayments**: If your account has been overpaid or if a payment is received in error, we will issue a refund upon request. Refunds will be issued in the same form as the original payment.

6. Collections

- **Unpaid Balances**: Balances unpaid for more than 90 days will be referred to Valley Collections, with an additional fee of 25% of the outstanding balance applied.
- **Inactive Accounts:** Accounts with overdue balances will be marked as “inactive,” preventing you from scheduling future appointments or receiving care until the balance is resolved. In the event of an urgent medical need while your account is inactive, seek care at the nearest hospital, emergency room, urgent care facility, or from your primary care physician.
- **Legal Fees**: If it becomes necessary to take legal action to collect an unpaid balance, you will be responsible for any legal fees and court costs incurred.

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Financial Policy

7. Fees and Deposits

- **Returned Checks:** A $25 fee will be charged for any returned checks, in addition to any bank fees incurred.
- **Medical Records:** You may access your medical records through our patient portal at no charge. For requests involving printed, faxed, or mailed records, a fee of $0.50 per page will apply and must be paid prior to the release of records.
- **Patient Forms:** A fee of $30 may apply for the completion and/or signing of forms outside of an office visit, including FMLA leave, disability, school forms, and insurance applications. This fee will not be billed to your insurance.
- **eNO Test:** The eNO test, FDA-approved and endorsed by the American Thoracic Society, will be billed to your insurance. If your insurance does not cover this test, you will be billed $26.
- **Patch Testing:** Due to the cost of creating individualized patch tests, a $100 deposit is required at the time of scheduling for patch tests. This fee does not apply to patients with Medicare and Medicaid.
- **Serum Extract:** For specific questions regarding financial responsibility, please consult your insurance provider. Patients who provide a signed allergy immunotherapy consent to our office, gives us the authorization to start the serum mixing/billing process.

8. Medicaid

- **Out-of-Pocket Costs**: If Medicaid does not cover certain services or treatments, you will be responsible for the cost of these services. We will provide you with an estimate of any out-of-pocket expenses before proceeding with non-covered services.
- **Self-Pay Option**: For services not covered by Medicaid, we offer self-pay options with discounted rates. Payment for these services is required at the time of service.
- **Secondary Insurance**: If you have secondary or tertiary insurance in addition to Medicaid, please provide details of these policies. Any balance not covered by Medicaid or additional insurance will be your responsibility.
- **Notification**: It is your responsibility to inform us immediately if there are any changes to your Medicaid eligibility or coverage. Failure to notify us of changes may result in you being responsible for the full cost of your services.
- **Eligibility Verification**: We may need to re verify your Medicaid eligibility periodically. If there are issues with verification, you may be asked to pay for services until eligibility is confirmed.

9. Authorizations and Referrals

- **Insurance Plan Requirements:** Many insurance plans, including but not limited to HMO (Health Maintenance Organization) plans, require a referral from your primary care physician or another designated provider before you can see a specialist or receive certain services. It is your responsibility to understand and comply with your insurance plan's referral requirements.
- **Obtaining Referrals:** If your insurance plan requires a referral for specialist visits or specific procedures, you must obtain this referral prior to your appointment with us. Failure to secure the necessary referral may result in your insurance not covering the services, leaving you responsible for the full cost.
- **Preauthorization:** In addition to referrals, some insurance plans may require preauthorization for certain procedures or treatments. We encourage you to verify with your insurance provider whether preauthorization is needed and to obtain it before your appointment.
- **Contact Information:** If you are uncertain about whether a referral is required or how to obtain one, please contact your insurance provider directly. Our staff can assist you with general information, but the responsibility for ensuring that referrals and preauthorizations are in place rests with you.
- **Responsibility for Charges:** If you attend an appointment or receive services without the required referral or preauthorization, you may be responsible for any charges not covered by your insurance. We will inform you of any such charges prior to the service being rendered, if possible.

Patient/Guardian Printed Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: ▢ Father ▢ Mother ▢ Grandparent ▢ Legal Guardian ▢ Self

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Patient Information Sheet

Patient Name: _____Date of Birth (DOB): _____/_____/_____
Nickname(s): _____ SSN: _____-_____-_____

Sex: ▢ Male ▢ Female ▢ Other
Gender Identity: ▢ Male ▢ Female ▢ Other
Race ▢ African American ▢ American Indian ▢ Asian ▢ Caucasian ▢ Hispanic
Ethnicity ▢ African American ▢ Asian ▢ Caucasian ▢ Eastern Indian ▢ Hispanic ▢ Native American ▢ Pacific Islander
Preferred Language: ▢ ASL ▢ English ▢ Spanish ▢ Other: _____**Interpreter Needed:** ▢ Yes ▢ No

Contact Information

Cell Phone: _____Home Phone: _____
Work Phone: _____Email Address: _____
Physical Address: _____
City: _____State: _____ Zip Code: _____
▢ *Select if same as physical address*
Mailing/Billing Address: _____
City: _____State: _____ Zip Code: _____

Primary Care Doctor *(PCP)* Information

Doctor's Name: _____ Phone Number: _____
Facility Name/Address:_____
Phone Number: _____ Fax Number:_____

Parent/Legal Guardian Information *(Complete if applicable)*

***Primary Parent/Guardian*:** _____Date of Birth: _____
Street Address: Street Address: ▢ *Select if same as patient*_____
City: _____State: _____ Zip Code: _____
Phone Number: _____ Email Address: _____
Relationship to Patient: ▢ Father ▢ Mother ▢ Grandparent ▢ Legal Guardian ▢ Sibling ▢ Other: _____
Secondary Parent/Guardian: _____Date of Birth:_____
Street Address: Street Address: ▢ *Select if same as patient*_____
City: _____State: _____ Zip Code: _____
Phone Number: _____ Email Address: _____
Relationship to Patient: ▢ Father ▢ Mother ▢ Grandparent ▢ Legal Guardian ▢ Sibling ▢ Other:
**If the parents are separated or divorced, please provide a copy of the parenting plan (if available) to help ensure proper medical decision-making and communication.*

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Insurance Information

To ensure accurate billing and processing of your claims, it is essential that you complete the Insurance Information section on this form, even if you have already provided a copy of your insurance card. The information requested on this form allows us to verify your coverage details and handle any discrepancies that may arise. Your cooperation in filling out this section is crucial for us to provide seamless care and billing services. Thank you for your understanding and attention to this matter.

Primary Insurance _____ ID: _____
Group Number: _____ Policy/Subscriber Name: _____
Subscriber's DOB: _____ Patient Relationship to Subscriber: _____
Address: _____
City, State, Zip: _____ Plan Phone Number: _____

Secondary Insurance _____ ID: _____
Group Number: _____ Policy/Subscriber Name: _____
Subscriber's DOB: _____ Patient Relationship to Subscriber: _____
Address: _____
City, State, Zip: _____ Plan Phone Number: _____

Pharmacy Card (if applicable)
Pharmacy Card Provider: _____
Member ID: _____ Group Number: _____
BIN Number: _____ PCN (Processor Control Number): _____
Phone: _____

Responsible Party (Bill To)
Name: _____ Date of Birth: _____
Street Address: □ *Select if same as patient* _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Email Address: _____
Relationship to Patient: □ Father □ Mother □ Grandparent □ Legal Guardian □ Sibling □ Other: _____

I, _____, acknowledge that the information I have provided on this Patient Information Sheet is accurate and complete. I understand it will be used for my care, billing, and communication with healthcare providers. I agree to notify San Tan Allergy & Asthma of any changes to my personal or insurance information. By signing below, I consent to the use and disclosure of my information as outlined and understand it will be kept confidential according to privacy laws.

Patient/Guardian Printed Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____

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Patient Disclosure and Communication Preferences

At San Tan Allergy & Asthma, we are committed to providing you with personalized and efficient care. To ensure that we communicate with you in the manner that best suits your preferences and to comply with privacy regulations, we ask you to complete the following Patient Disclosure and Communication Preferences Form. This form allows you to specify your preferred methods of communication, authorize individuals with whom we may discuss your health information, and provide consent for receiving detailed messages regarding your care. Your responses will help us tailor our communication to your needs and preferences while safeguarding your privacy.

1. Preferred Methods of Communication

Phone calls are our primary method of communication. If you wish to receive notices through other methods, please indicate them below:

▢ **Phone Call -** Calls may be made to the phone numbers listed in your contact information.
▢ **Text / SMS Message -**Text/SMS messages will be sent to the primary phone number on file. They will be limited in the information provided to protect your privacy.
▢ **Patient Portal -** Notifications will be sent to the email address provided in your contact details.
▢ **Email -**Emails will be sent to the email address provided in your contact details.
▢ **Mail -**Correspondence will be sent to the mailing/billing address provided in your contact details.

2. Consent for Detailed Messages

Please indicate whether you consent to receive detailed messages about your health information:

▢ I consent to receive detailed messages about my health information using the contact methods provided.
▢ I **do not** wish to receive detailed messages about my health information. I understand that this may require me to schedule an appointment for a review of my health information in person.

3. Authorized Contacts

Please list individuals with whom we may disclose your health information:

- **Name:** _____ **Phone Number:** _____
  Relationship to Patient: ▢ Father ▢ Mother ▢ Grandparent ▢ Legal Guardian ▢ Sibling ▢ Spouse
- **Name:** _____**Phone Number:** _____
  Relationship to Patient: ▢ Father ▢ Mother ▢ Grandparent ▢ Legal Guardian ▢ Sibling ▢ Spouse
- **Name:** _____**Phone Number:** _____
  Relationship to Patient: ▢ Father ▢ Mother ▢ Grandparent ▢ Legal Guardian ▢ Sibling ▢ Spouse

I, _____ (patient name), confirm that I have reviewed and understand the contents of this Patient Disclosure and Communication Preferences Form. I authorize the communication methods and disclosure of my health information as specified above. I understand that I may update these preferences at any time by notifying San Tan Allergy & Asthma in writing.

Patient/Guardian Printed Name: _____Date of Birth: _____

Patient/Guardian Signature: _____Date: _____

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Patient and Visitor Code of Conduct

San Tan Allergy & Asthma is committed to providing exceptional care within a safe, respectful, and inclusive environment for all patients and visitors. To ensure that we maintain these high standards, we request that everyone within our practice adheres to the following guidelines:

1. Respect and Dignity

We are dedicated to treating every individual with kindness, dignity, and respect. Discriminatory remarks or actions based on race, religion, gender, sexual orientation, or personal attributes are strictly prohibited. Our commitment extends to ensuring that no one is refused care based on these traits. Respect for each individual is the foundation of our practice.

2. Appropriate Behavior

All patients and visitors are expected to engage in respectful and appropriate language and behavior at all times. This includes avoiding physical or verbal threats, abusive language, and suggestive or explicit gestures. Our goal is to create a positive and professional atmosphere conducive to quality healthcare.

3. Privacy and Disruption

Respecting patient privacy is of utmost importance. We ask that all patients and visitors refrain from any actions that could disrupt the care or experience of other patients. This includes maintaining a quiet and respectful environment in our waiting and treatment areas.

4. Consent for Recording

Any form of photography, video, or audio recording within our facility requires explicit prior consent from all individuals involved. This policy ensures that the privacy of all patients and staff is protected and that any recordings are made with proper authorization.

Consequences for Policy Violations

- **Patients:** Failure to comply with these guidelines may result in being asked to leave and seek alternative non-emergency care. In cases of severe violations, a review of eligibility for future non-emergency services at San Tan Allergy & Asthma may be necessary. Patients will have the opportunity to present their perspective before any decisions regarding their continued care are made.
- **Visitors:** Visitors who do not adhere to these guidelines may be asked to leave the premises and could face restrictions on future visits. Ensuring a respectful environment is essential for everyone's safety and comfort.
- **General Actions:** Violations of this policy may result in verbal counseling and/or discharge from the practice. Persistent non-compliance may lead to further actions, including potential discharge from our practice.

By signing below, you acknowledge that you have received and reviewed this information and agree to adhere to these guidelines for appropriate conduct.

Patient/Guardian Printed Name: _____Date of Birth: _____

Patient/Guardian Signature: _____Date: _____

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Medical History

Name:_____ **Dob:**_____ **Date:**_____

CHIEF COMPLAINT

- ▢ Adverse Drug Reaction
- ▢ Allergic Rhinitis
- ▢ Angioedema
- ▢ Asthma
- ▢ Atopic Dermatitis
- ▢ Eosinophilic Esophagitis
- ▢ Food Allergies
- ▢ FPIES
- ▢ Immune Deficiency
- ▢ Urticaria
- ▢ Other (please specify): _____

_____

PRIMARY SYMPTOMS

Nasal Symptoms - ▢ Discharge ▢ Postnasal Drip ▢ Sneezing ▢ Congestion ▢ Loss of smell/taste
Chest Symptoms - ▢ Cough ▢ Wheeze ▢ Shortness of breath ▢ Chest Tightness
Eye Symptoms - ▢ Itchiness ▢ Redness ▢ Watery
Sinus Symptoms - ▢ Sinus Infections ▢ Facial pain and tenderness ▢ Pressure and congestion ▢ Headaches
Skin Symptoms - ▢ Hives ▢ Eczema ▢ Swelling

ALLERGIES

(Please check off if you have allergies to any of the following. If applicable, include the allergy and symptoms)

▢ Medication - _____

_____

_____

▢ Food - _____

_____

_____

- ▢ Latex
- ▢ Venom

PAST MEDICAL AND SURGICAL HISTORY

(Please check off if you have had any problems with or are presently experiencing any of the following)

- ▢ Allergic Rhinitis
- ▢ Anaphylaxis
- ▢ Asthma
- ▢ Atopic Dermatitis
- ▢ Auto Immune Disorder(s)
- ▢ Bronchiestasis
- ▢ Cardiovascular Conditions (i.e Hypertenson)
- ▢ COPD
- ▢ Dyspagia
- ▢ ENT Conditions (i.e Nasal Polyps)
- ▢ EGPA
- ▢ Eosinophilic Esophagitis
- ▢ GERD (Reflux)
- ▢ Headaches / Migraines
- ▢ Hypereosinophilic Syndrome
- ▢ Immune Deficiency
- ▢ Mast Cell Activation Syndrome
- ▢ Urticaria (Hives)
- ▢ Other (please specify):_____

_____

_____

_____

▢Surgery:_____

_____

_____

_____

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Medical History

CURRENT MEDICATIONS

San Tan Allergy and Asthma may access your medication refill history through SureScripts, a secure electronic network that allows healthcare providers to view and manage medication histories. This service helps us provide more accurate and efficient care by reviewing your medication history from pharmacies and healthcare providers. Please be aware that not all medications may appear on SureScripts. For example, certain medications, such as those prescribed by specialists or not filled through participating pharmacies, may not be included in the network. Regardless of what is available through SureScripts, it is important that you list all medications you are currently taking, including prescription medications, over-the-counter drugs, and supplements. This ensures we have a complete understanding of your health and can provide the best possible care.

Please indicate below if you do or do not authorize us to use this resource:
[ ] I authorize San Tan Allergy and Asthma to access my medication refill history through SureScripts.
[ ] I do not authorize San Tan Allergy and Asthma to access my medication refill history through SureScripts.

Please list all medications you are currently taking:

Name	Strength	Dose	Frequency

FAMILY HISTORY

(Please check off if any of the following conditions are present in your family members)

	MOTHER	FATHER	SIBLINGS	GRANDPARENT
Allergic Rhinitis:	▢	▢	▢	▢
Anaphylaxis	▢	▢	▢	▢
Asthma:	▢	▢	▢	▢
Atopic Dermatitis:	▢	▢	▢	▢
Auto Immune Disorder(s)	▢	▢	▢	▢
Bronchiestasis	▢	▢	▢	▢
Cardiovascular Conditions (i.e Hypertension)	▢	▢	▢	▢
COPD	▢	▢	▢	▢
Dyspagia	▢	▢	▢	▢
ENT Conditions (i.e Nasal Polyps)	▢	▢	▢	▢
EGPA	▢	▢	▢	▢
Eosinophilic Esophagitis	▢	▢	▢	▢
GERD (Reflux)	▢	▢	▢	▢
Headaches / Migraines	▢	▢	▢	▢
Hypereosinophilic Syndrome	▢	▢	▢	▢
Immune Deficiency	▢	▢	▢	▢
Mast Cell Activation Syndrome	▢	▢	▢	▢
Urticaria (Hives)	▢	▢	▢	▢
Other (please specify):	▢	▢	▢	▢

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Medical History

SOCIAL HISTORY

Marital Status ▢ Married ▢ Divorced ▢ Seperated ▢ Widowed ▢ Single ▢ Significant Other
Smoking Status ▢ Never Smoked ▢ Current Smoker ▢ Former Smoker
Exposure to secondhand smoke ▢ Yes ▢ No
If the patient is a child, the patient lives with ▢ Both Parents ▢ Mother ▢ Father ▢ Foster Family ▢ Other:

ENVIRONMENTAL HISTORY

Current Home ▢ Single Family Home ▢ Apartment ▢ Townhouse/Condo/Duplex
Home Setting ▢ Farm ▢ Rural ▢ Suburban ▢ Urban/City
Flooring ▢ Carpet ▢ Tile/Linoleum ▢ Wood
Air Conditioning/Heating ▢ Central A/C & Heating ▢ Swamp Cooler ▢ Wall Unit ▢ Wood Stove
Animals ▢ None ▢ Dog(s) ▢ Cat(s) ▢ Bird(s) ▢ Gerbil/Guinea Pig(s) ▢ Chicken(s) ▢ Horse(s) ▢ Other:
Animals Reside ▢ Inside Only ▢ Outside Only ▢ Both Indoor & Outdoor ▢ Pet(s) sleep in the bedroom

PHARMACY INFORMATION

(Please provide your preferred pharmacy details below so we can ensure your prescriptions are sent to the right place.)

- Short-term prescriptions (e.g., antibiotics, pain relievers, or other medications for temporary conditions) will be sent to your local pharmacy for in-person pickup.
- Long-term prescriptions (e.g., medications for chronic conditions) will be processed through a mail-order pharmacy for the convenience of home delivery, often with a 90-day supply.

1. Local Pharmacy

Pharmacy Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Cross Streets: _____

2. Mail-Order Pharmacy (if applicable)

Pharmacy Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Account/Member ID: _____

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Notice and Acknowledgement of Privacy Practices

Effective Date: January 1, 2026

San Tan Allergy & Asthma ("we," "our," or "us") is dedicated to safeguarding the privacy and confidentiality of your health information. This Notice of Privacy Practices explains how we collect, use, and disclose your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). We encourage you to read this notice carefully to understand your rights and our responsibilities regarding your health information.

1. Uses and Disclosures of Your Health Information

We may use and disclose your PHI for various purposes, including:

- **Treatment:** To provide, coordinate, or manage your healthcare services. This includes communication with other healthcare providers involved in your care to ensure comprehensive treatment.
- **Payment:** To obtain payment for services rendered. This involves billing activities, collections, and providing necessary information to your health insurance company.
- **Healthcare Operations:** To carry out essential healthcare-related activities such as quality assessment, improvement initiatives, and administrative functions necessary for effective operations.

In addition to these purposes, we may also use and disclose your PHI under specific circumstances, including:

- **As Required by Law:** To comply with applicable federal, state, or local laws.
- **Public Health Activities:** To report diseases, injuries, and to assist with public health investigations.
- **Health Oversight Activities:** To regulatory agencies responsible for overseeing healthcare providers.
- **Judicial and Administrative Proceedings:** In response to court orders or legal processes.
- **Law Enforcement:** To support law enforcement investigations and activities.
- **Medical Examiners and Funeral Directors:** To notify and assist these professionals in performing their duties.
- **Research:** For research purposes, subject to conditions and approvals designed to protect your privacy.

2. Your Rights Regarding Your Health Information

You have several rights concerning your PHI:

- **Right to Access:** You may request access to and obtain copies of your health information, subject to certain exceptions as permitted by law.
- **Right to Request Amendments:** You may request amendments to your health information if you believe it is inaccurate or incomplete. We will review your request and make amendments as appropriate.
- **Right to an Accounting of Disclosures:** You may request an accounting of disclosures of your health information made for purposes other than treatment, payment, and healthcare operations.
- **Right to Request Restrictions:** You may request restrictions on how we use or disclose your health information. While we are not obligated to agree to all requests, we will consider your request and respond appropriately.
- **Right to Confidential Communications:** You may request that we communicate with you in a specific manner or at a particular location to protect your privacy.
- **Right to a Paper Copy of This Notice:** You may request a paper copy of this Notice at any time, even if you have agreed to receive it electronically.

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Notice and Acknowledgement of Privacy Practices

3. Our Responsibilities

We are committed to:

- **Maintaining the Privacy of Your Health Information:** Adhering to the privacy practices outlined in this Notice to protect your health information.
- **Providing This Notice:** Ensuring you receive a copy of this Notice and informing you of any changes.
- **Complying with This Notice:** Following the privacy practices described in this Notice consistently.

4. Changes to This Notice

We reserve the right to modify our privacy practices and update this Notice at any time. Changes will apply to all health information we maintain, including information created or received before the change. We will post the updated Notice in our office and provide you with a copy upon request.

5. Contact Us

For any questions regarding this Notice or to exercise your rights, please contact us at:
San Tan Allergy & Asthma
Address: 4915 E. Baseline Rd #112, Gilbert, Arizona 85234
Phone Number: 480-626-6600

6. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health & Human Services. We assure you that no retaliation will occur for filing a complaint.
To file a complaint with us, please contact:
San Tan Allergy & Asthma
Attention: Privacy Officer
Address: 4915 E. Baseline Rd #112, Gilbert, Arizona 85234
Phone Number: 480-626-6600

Acknowledgment of Receipt

I, _____ (patient name), acknowledge that I have received a copy of the San Tan Allergy & Asthma Notice of Privacy Practices, effective January 1, 2026. I understand that this Notice describes how my protected health information may be used and disclosed and outlines my rights regarding my health information.
By signing below, I consent to the use and disclosure of my PHI as described in this Notice.

Signature: _____Date: _____

Print Name: _____Relationship to Patient (if applicable): _____