

**Board Certified Specialists in Allergy, Asthma & Immunology**

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

Appointment Time: \_\_\_\_\_

Dr.: \_\_\_\_\_

Location: \_\_\_\_\_

Dear New Patient,

Welcome to our practice. Here is some information that will help make your first visit a little easier.

**Enclosed with this letter are the following:**

1. New patient information forms.
2. Green sheet which gives us information about your allergic history.
3. Directions to our locations.
4. Records release form.

Please request that your records be sent to us prior to your visit from your primary care/pediatrician and/or specialists such as pulmonologist/ENT/dermatologist.

5. Patient Compliance & Cancellation Policy.
6. Agreement and consent for medical services.
7. Notice of Privacy Practices.
8. Antihistamine Medications List.
9. Insurance and referral information form.

Please complete your forms and bring them with you on the day of your visit along with your insurance card and any necessary referrals.

**The first visit takes between two to three hours.** We ask that you do not bring siblings/children due to this length of time. **Patients should discontinue ALL antihistamines at least seven days before coming for testing. If you are on beta-blockers, we ask you to contact us regarding this medication.** Wearing clothes that allows easy access to the back and upper arms is advisable. We also advise patients to bring along a sweatshirt or zip-up fleece.

Because of the length of time we have set aside for you, we ask that you let us know at least 48 hours in advance if you are not able to keep this appointment.

We look forward to meeting you. If you have any questions prior to the visit, please call us at 865-588-2753.

Jane R. Conley, M.D.  
Sangeetha M. Kodoth, M.D.



1346 DOWELL SPRINGS BOULEVARD•KNOXVILLE, TN 37909
PHONE: (865) 588-2753 FAX: (865) 588-7418

JANE R. CONLEY, M.D.

SANGEETHA M. KODOTH, M.D

Welcome to our practice!

Patient's full name: Last First Middle

Are there any other names under which we might find you/your child's medical records (maiden name, name prior to adoption)?

If so, please list:

Home Address Street City State Zip

Home phone: Cell: Work phone:

Employer: Occupation:

Work address: Street City State Zip

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Sex: ( ) Female ( ) Male

Birth Date: Social Security Number:

Drivers' License Number: State:

Spouse/Parent name:

Address (if different): Street City State Zip

Home phone: Cell: Work Phone:

HOW did you learn about our practice: (Please circle all that apply): Telephone Book Online Yellow Pages

Referred by a Friend or Family Member Our Web Site Other Web Site: Received Info in the Mail

TV: Radio: Newspaper: Magazine:

Referred by a physician (please list):

Referring Physician's Address: Street City State Zip

Who is your primary care physician?

Mailing Address: Street City State Zip

Please list any doctor you would want to receive a copy of your evaluation. (Referring physicians will automatically receive a copy, unless you tell us otherwise):

Please continue on the other side

**PRIVACY INFORMATION:** You will receive a copy of our Notice of Privacy for Personal Health Information Policy. Extra copies can be found in our lobby, and can also be printed from our web site. The following statements direct us regarding how we handle your personal information.

I authorize Allergy Specialists of Knoxville, PLLC:

1. To notify me by mail and phone of appointment reminders and/or to contact me regarding medical information (including test results). A message may be left on my home answering machine. YES NO

2. If unable to reach me at home, the practice of Allergy Specialists of Knoxville, PLLC, may leave a message where I work, asking me to return their call YES NO

3. Please list the names of family members, if any, with whom we may share your medical information: \_\_\_\_\_

**I acknowledge I have received a copy of Allergy Specialists of Knoxville, PLLC's Notice of Privacy for Personal Health Information.**

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

Signature of Patient or Person Authorized to Consent for Patient

Please print patient's name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Please print name of person signing for patient (if applicable): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**INSURANCE INFORMATION (Please allow us to make copies of your insurance cards.)**

Primary Insurance: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

**INSURED'S INFORMATION (who is the primary holder of the insurance?)**

Insured's full name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Insured work phone: \_\_\_\_\_

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

Street

City

State

Zip

Insured's Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_

**BILLING INFORMATION IF PATIENT IS A CHILD (under 18 yrs): (person attending the appointment with the child)**

Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Street

City

State

Zip

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

Work Phone: \_\_\_\_\_ Drivers license number: \_\_\_\_\_ State: \_\_\_\_\_

**EMERGENCY INFORMATION:** In an emergency, notify: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

## **Patient Compliance & Cancellation Policy**

**Our mission is to provide our patients the most comprehensive and compassionate healthcare. Your treatment here will be unlike most healthcare experiences you have had in the past. We believe that if we spend more time with each patient we will achieve better results. Therefore, we schedule only one new patient or one allergy testing patient each hour.**

**In order to offer our patients this kind of service, we need your compliance with our policies. Consistent attendance to appointments is essential to your improvement. When you schedule an appointment, that time is reserved especially for you. When you miss an appointment without advanced notice, not only does it interfere with your progress, your doctor does not have the opportunity to offer that time to someone else in need of treatment.**

**We understand that sometimes things happen that are out of your control. Therefore, we ask that you give us at least 24 hours notice if you have to cancel your appointment. This will allow us to offer that hour appointment slot to another patient. If you find out after the office is closed (after hours, weekend or holiday) that you are unable to attend an appointment the next day, we requested that you call the office and leave a message with the answering service. Otherwise, cancellations should be called in during regular business hours.**

**If you miss an appointment without 24 hours notice, there will be a fee assessed. The fee is due when you are billed or at the next appointment, whichever comes first. These fees are the responsibility of the patient, as they are not covered by any third party payor.**

**The fee schedule is as follows:**

- First incidence within six months \$20**
- Second incidence within six months \$25**
- Third incidence within six months \$40**
- Fourth incidence within six months (we reserve the right to discharge you from our care)**

**We thank you for working with us to allow us to provide you the best possible care.**

**I acknowledge that I understand the meaning and purpose of the above information.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**AGREEMENT AND CONSENT FOR MEDICAL SERVICES**

*Please initial each statement and sign at the bottom*

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

\_\_\_\_\_ **Agreement and consent for minors:** I am the parent/legal guardian representative of  
*Initials* \_\_\_\_\_ (the "Patient") and am authorized to act on her/his behalf. I  
 hereby authorize medical services to be provided to the "Patient" by the physicians and medical staff of  
 Allergy Specialists of Knoxville.

\_\_\_\_\_ **Release of Information:** I hereby authorize Allergy Specialists of Knoxville, PLLC, to release to  
*Initials* governmental agencies, third party payers and other agencies any information reasonably requested by  
 such parties, including any information necessary for Allergy Specialists of Knoxville, PLLC to obtain  
 payment for its services.

\_\_\_\_\_ **Long Term Physician Authorization:** I authorize Allergy Specialists of Knoxville, PLLC, to furnish  
*Initials* information or records regarding the above patient to other physicians or health care professionals  
 involved in his/her care.

\_\_\_\_\_ **Assignment of Insurance Benefits:** I authorize and request that payment be made directly to  
*Initials* Allergy Specialists of Knoxville, PLLC for any insurance benefits payable for services provided to the  
 Patient by Allergy Specialists of Knoxville, PLLC. This authorization expressly includes any benefits that  
 are to be provided by TennCare and any other public or private insurance plans. This request will  
 remain in effect until revoked by me in writing.

\_\_\_\_\_ **Acknowledgement of Financial Responsibility:** While there may be insurance benefits available  
*Initials* to pay for the medical services provided to the Patient by Allergy Specialists of Knoxville, PLLC, I  
 understand that all services may not be covered by insurance or that payment may be less than 100%  
 of charges billed. I agree to pay any required co-pay amount and any deductible amount. I further agree  
 to pay for any services rendered to the Patient by Allergy Specialists of Knoxville, PLLC which are not  
 paid by insurance, due to lack of referral or any other reason.

\_\_\_\_\_ **Acknowledgement of Notice of Privacy for PHI:** I acknowledge that I have received a Copy of  
*Initials* Allergy Specialists of Knoxville, PLLC Notice regarding Privacy of Personal Health Information

\_\_\_\_\_ **Acknowledgement of Patient Compliance and Cancellation Policy:** I acknowledge and agree that I  
*Initials* will be accessed a fee when a scheduled appointment is not cancelled within 24 hours. This fee is  
 my responsibility and I understand it is not covered by my insurance plan.

Printed Name of Patient: \_\_\_\_\_

Signature of Patient/Patient Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor, please print name of person signing for patient: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

***Thank you!***



### Insurance Cards

We are required to have a copy of your insurance card and current valid driver's license on file to provide proof of insurance and in order to bill your insurance for you. If we do not have this information on file, you are solely responsible for all charges and payment is expected at the time of service. Once we receive the appropriate insurance documentation, your insurance company will be billed and you will be refunded when the insurance company pays.

You must present your insurance card(s) at each appointment to help us provide the most efficient and trouble-free processing of your claim. If your insurance changes, please be sure to notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. **If insurance denies your visit coverage and we were not notified of any changes to your coverage the balance will automatically be billed to you and become your responsibility.**

### Referrals

Some insurance carriers require that a patient obtain a referral from their primary care physician in order for the insurance to pay for care by a specialist physician. Most insurance carriers do not require a referral, but if yours does it is your responsibility to ensure that the referral is in effect prior to visiting our office. Some referral are good for 9 months to 1 year, others require referrals per visit. If your insurance company authorizes a referral yearly, it is your responsibility to update that referral.

To get a referral you must contact your primary care physician's office. If your insurance requires a referral and you don't have an approved referral from the insurance carrier we will still be happy to see you at your appointed time. **If we do not receive your referral within two days, you will be responsible for payment in full for all services rendered.**

I, \_\_\_\_\_ have read and acknowledge the above information.  
Print Your Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



JANE R. CONLEY, M.D.  
SANGEETHA M. KODOTH, M.D.

BOARD CERTIFIED SPECIALISTS IN  
ALLERGY, ASTHMA & IMMUNOLOGY

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

To: \_\_\_\_\_

RE: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(please print patient's name)

I hereby authorize you to release to Dr. Conley/Dr. Kodoth any information regarding medical treatment rendered to me/my child during the period from \_\_\_\_\_ to \_\_\_\_\_.

Please include all information regarding examinations, testing, diagnostic lab work, x-rays and treatment.

Thank you!

\_\_\_\_\_  
Patient/Parent Signature

\_\_\_\_\_  
Relationship to patient

**1346 Dowell Springs Blvd, Knoxville, TN 37909**  
**Phone: 865-588-2753 Fax: 865-588-7418**



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JANE R. CONLEY, M.D

SANGEETHA M. KODOTH, M.D.

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Person answering questions: \_\_\_\_\_

If the patient is a child, who does the child live with? \_\_\_\_\_

How long have you lived in East Tennessee? \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Please list other doctors you see regularly with their specialty: \_\_\_\_\_

**PERSONAL HISTORY:**

SYMPTOMS: (Please circle the symptoms that bother you.)

- |              |            |                |                  |                     |                     |
|--------------|------------|----------------|------------------|---------------------|---------------------|
| Hay fever    | Sneezing   | Congestion     | Runny nose       | Itchy nose          | Watery, itchy eyes  |
| Snoring      | Fatigue    | Itchy throat   | Sore Throat      | Throat Clearing     | Trouble Sleeping    |
| Irritability | Headaches  | Frequent colds | Sinus infections | Ear infections      | Loss of smell/taste |
| Asthma       | Bronchitis | Cough          | Frequent croup   | Shortness of breath |                     |

Do your ears pop or feel as if they need to pop? \_\_\_\_\_ Do you ever stop breathing in your sleep? \_\_\_\_\_

Does your nose run excessively with temperature changes? \_\_\_\_\_ or with eating? \_\_\_\_\_

Are your symptoms year round or just at certain times? What months of the year are they worse? \_\_\_\_\_

What makes your symptoms worse? What makes them better? Do vacations change your symptoms? \_\_\_\_\_

Do you have symptoms with exposure to the following? (Please circle those that apply to you.)

- |                                  |      |          |                 |               |                  |      |
|----------------------------------|------|----------|-----------------|---------------|------------------|------|
| Heat                             | Cold | Exercise | Weather changes | Rainy weather | Damp musty areas | Dust |
| Strong odors (perfumes/cleaners) | Cats | Dogs     | Cigarette smoke |               |                  |      |

Are you different indoors versus outdoors? \_\_\_\_\_

Number of days of school or work missed during the past year? \_\_\_\_\_

Do you think you have any problems with the following (If you checked "yes" please explain in the space provided):

Latex: \_\_\_\_ no \_\_\_\_ yes \_\_\_\_\_



Did you take any medications in the past 24 hours (please list)? \_\_\_\_\_

When did you last have antibiotics? \_\_\_\_\_ Which one? \_\_\_\_\_

When did you last have oral steroids (such as prednisone)? \_\_\_\_\_

Are you able to tolerate prednisone? \_\_\_\_\_

Do you ever take aspirin or other NSAIDS (ibuprofen, etc.)? \_\_\_\_\_

**PAST MEDICAL HISTORY:** (Please give dates and explain briefly.)

Other medical problems unrelated to your allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emergency room visits: \_\_\_\_\_

\_\_\_\_\_

Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries: \_\_\_\_\_

\_\_\_\_\_

Are patient's immunizations up to date? \_\_\_\_\_ no \_\_\_\_\_ yes Has patient had the chicken pox vaccine \_\_\_\_\_ no \_\_\_\_\_ yes

Have you (your child) had the pneumonia vaccine? \_\_\_\_\_ no \_\_\_\_\_ yes

Have you had any adverse reactions to vaccines? \_\_\_\_\_

**TESTING AND TREATMENTS:** (Please give dates and places if you can.)

Have you had a chest x-ray (where and when)? \_\_\_\_\_

Have you had a sinus x-ray or CT scan (circle one)? \_\_\_\_\_

Have you been allergy tested \_\_\_\_\_ If so, when and please give the doctor's name: \_\_\_\_\_

Did you have allergy shots? \_\_\_\_\_ Did they help? \_\_\_\_\_

**FAMILY HISTORY:** (Please tell us which of your relatives have the following illnesses, if any)

Hay fever \_\_\_\_\_

Sinusitis \_\_\_\_\_

Asthma \_\_\_\_\_

Latex allergy \_\_\_\_\_

Food allergy \_\_\_\_\_

Medication allergy \_\_\_\_\_

Insect (bee sting) allergy \_\_\_\_\_

Eczema \_\_\_\_\_

Hives or allergic swelling (urticaria or angioedema) \_\_\_\_\_

Cystic Fibrosis \_\_\_\_\_

Emphysema \_\_\_\_\_

Tuberculosis \_\_\_\_\_

**SOCIAL HISTORY:**

Educational background (grade in school now, high school, college, technical school): \_\_\_\_\_

\_\_\_\_\_

For adults: What type of job do you do? \_\_\_\_\_

For kids: What grade are you in OR does child attend daycare? \_\_\_\_\_

Does the work or school environment seem to make you (your child) worse? \_\_\_\_\_

\_\_\_\_\_

Is there any exposure to chemicals, fumes or hazardous materials? \_\_\_\_\_

Do you smoke now? \_\_\_\_\_ no \_\_\_\_\_ yes If so, how much? \_\_\_\_\_

Did you ever smoke in the past \_\_\_\_\_ no \_\_\_\_\_ yes If so, how many packs per day? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_ How long ago did you quit smoking? \_\_\_\_\_

Did you use: \_\_\_\_\_ Cigars \_\_\_\_\_ Pipe \_\_\_\_\_ Smokeless tobacco Alcohol: \_\_\_\_\_ None \_\_\_\_\_ Occasional \_\_\_\_\_ Daily

**ENVIRONMENTAL HISTORY:**

Do you live in the city or the country? \_\_\_\_\_ Do you live on a farm? \_\_\_\_\_

Heating: forced air electric baseboard wood stove radiators Do you have air conditioning? \_\_\_\_\_ window or central

Age of house \_\_\_\_\_ year(s) How long have you lived there? \_\_\_\_\_

Do you have a basement? \_\_\_\_\_ no \_\_\_\_\_ yes Does it get: wet damp moldy musty

**Patient's Bedroom** (please circle all that apply): carpet hardwood tile linoleum

Windows have: blinds washable curtains/drapes dry clean only curtains/drapes

Do you use a vaporizer? \_\_\_\_\_ Do you use a dehumidifier? \_\_\_\_\_

How old is your mattress? \_\_\_\_\_ Do you have: stuffed animals upholstered furniture ceiling fans

Animal Exposure (please tell us what kind of animals):

Indoor (home) \_\_\_\_\_ Friend/relative \_\_\_\_\_ School/work \_\_\_\_\_

Outdoor (home) \_\_\_\_\_ Friend/relative \_\_\_\_\_ School/work \_\_\_\_\_

If you have indoor animals, do they go into your (your child's) bedroom? \_\_\_\_\_

If you previously had indoor animals, what type did you have? \_\_\_\_\_

How long were they indoors? \_\_\_\_\_ How long have they been gone? \_\_\_\_\_



JANE R. CONLEY, M.D.  
American Board of Pediatrics  
American Board of Allergy & Immunology

SANGEETHA M. KODOTH, M.D.  
American Board of Pediatrics  
American Board of Allergy & Immunology

I, \_\_\_\_\_ (parent) and \_\_\_\_\_ (parent)  
authorize the following adult(s) to bring my child, \_\_\_\_\_ for  
his/her allergy shots and/or medical visits (**please circle one or both of these options**).

These individuals have the right to authorize medical treatment under the direction of the doctor on  
call if such treatment is needed.

Adults who may bring child for shot or visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## Antihistamine Medications: A Partial List

**Antihistamine medications can affect allergy skin testing. Please check the labels of all medications you are using (including nasal sprays and eye drops) to determine whether your medications contain any ingredient listed below. For questions, contact your pharmacist or our office.**

**· Stop these oral antihistamines 7 days before your appointment:**

- Claritin®, Claritin D®, Alavert® (loratadine), Clarinex®, Clarinex D® (desloratadine)
- Allegra®, Allegra D® (fexofenadine)
- Zyrtec®, Zyrtec D® (cetirizine), Xyzal® (levocetirizine)
- Actifed®, Dimetapp® (brompheniramine)
- Atarax®, Vistaril® (hydroxyzine)
- Benadryl® (diphenhydramine)
- Chlortrimeton®, AHist®, LoDrane 24®, LoDrane 24D®, (chlorpheniramine)
- Phenergan® (promethazine)
- Tavist®, Antihist® (clemastine)
- Periactin® (cyproheptadine)
- Actifed®, Aller-Chlor®, Bromfed®, Drixoral®, Dura-tab®, Novafed-A®, Ornade®, Poly-Histine-D®, Trinalin®, Extendryl Jr.®, Vasobid®, Vasotan®, Tussioncx Cough Syrup® (Combination medicines)
- Over-the-counter cold remedies (Nyquil®, doxylamine, pyrilamine, pheniramine)
- Motion sickness and dizziness medications (Antivert®, Bonine®, Dramamine®, meclizine, dimenhydrinate)
- Heartburn medications (Zantac®, ranitidine, Tagamet®, cimetidine, Pepcid®, famotidine)

**· The following antihistamine nasal sprays should be avoided for 7 days prior to testing:**

- Astelin®, Astepro®, Patanase®

**· The following antihistamine eye drops should be avoided for 7 days prior to testing:**

- Patanol®, Pataday®, Zaditor®, Optivar®, Elestat®, Alaway®, Visine Allergy Eye Drops®

## Medications That Do Not Interfere with Allergy Skin Testing

The following medications listed below **DO NOT** interfere with skin testing and may be continued up until your allergy appointment. (This list is not all inclusive, but it does include some of the more common medications that our new patients may be taking.)

Decongestants: Sudafed ®, pseudoephedrine, phenylpropanolamine

Leukotriene Inhibitors: Singulair ®, Accolate ®, Zflo ®

Corticosteroids: prednisone, prednisolone, methylprednisolone, Medrol ®, Orapred ®

Corticosteroid Nose Sprays: Nasonex ®, Nasacort AQ ®, Omnaris ®, fluticasone, Flonase ®, Veramyst ®, Rhinocort Aqua ®

Expectorants: Mucinex ®, guaifenesin

Cough suppressants: Delsym ®, dextromethorphan

Asthma inhalers and all nebulized asthma medications: all are OK – please do not stop them for testing

Reflux medications: Protonix ®, Prevacid ®, Aciphex ®, Nexium ® , Prilosec ®, omeprazole

### Other medications that do not affect skin testing include:

Antibiotics

Anticonvulsant medications

Arthritis medications

Birth control pills and female hormones

Cardiac medications

Cholesterol medications

Diabetes medications

Eye drops used for glaucoma, steroid eye drops

Thyroid medications

Most medications for hypertension (high blood pressure) including: Norvasc ®, amlodipine, Cardizem ®, diltiazem, felodipine, Cardene ®, nifedipine, Procardia ®, nifedipine, nisoldipine, Calan ®, Veralan ®, verapamil, Lotensin ®, benazepril, Atacand®, candesartan, Capoten ®, captopril, Vasotec®, enalapril, Monopril ®, fosinopril, Avapro ®, irbesartan, Cozaar ®, losartan, Benicar ®, olmesartan, Accupril ®, quinapril, Micardis ®, telmisartan, Diovan ®, valsartan. **If you are taking a BETA BLOCKER, please tell our receptionist when scheduling your appointment.**

Most medications for insomnia and depression including: Ambien, zolpedem, Lunesta, Xanax, alprazolam, Ativan, lorazepam, Valium, diazepam, Prozac, fluoxetine, Effexor, venlafaxine, Zoloft, sertraline, Celexa, citalopram, Lexapro, escitalopram, Wellbutrin, bupropion, Paxil, paroxetine, Cymbalta, duloxetine.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chose by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

- **Right to Amend.** If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- \* Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- \* Is not part of the medical information kept by or for the Practice;
- \* Is not part of the information which you would be permitted to inspect and copy; or
- \* Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) year back, and may not include dates before April 1, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction limitation on the medical information we use or disclose about you for treatment, payment or health care operation. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is exempted from the cost requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you indicate;

- \* what information you want to limit;
- \* whether you want to limit our use, disclosure or both; and
- \* to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail or the like.

To request confidential communication, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to paper copy of this notice.



## NOTICE OF PRIVACY PRACTICES

### **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**

This notice describes our Practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart (including physicians, medical assistants, medical students, RN's etc);
- All areas of the Practice (front desk, administration, billing and collections, etc.);
- All employees, staff and other personnel who work for or with our Practice;
- Our business associates (including a billing service, collection agency, or facilities to which we refer patients), on-call physicians, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

#### **OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:**

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to:

- make sure that the protected health information about you is kept private;
- provide you with Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.

#### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures proves a general explanation and provides some examples of uses. Not every use of disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

- **Medical Treatment.** We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the Practice also may share medical information about you including your record(s), prescriptions, request of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave the Practice; this may include your family members, or other personal representative authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

- **Payment.** We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether you plan will cover the treatment, to facilitate payment of a referring physician, or the like.

- **Health Care Operations.** We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are or not needed, and whether certain new treatments are effective.

We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. We may use or disclose information about you for internal or external utilization review and/or quality assurance, to business associate for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

• **Appointment and Patient Recall Reminders.** We may ask that you sign in writing at the Receptionist's Desk, a "Sign In" log on the day of your appointment with the Practice. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or other wise and may involve the leaving an e-mail, a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others.

• **Emergency Situation.** In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

• **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluate a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or discloser is not required.

• **Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

• **Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

• **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

• **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• **Public Health Risks.** Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

• **Investigation and Government Activities.** We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government programs and compliance with civil rights law.

• **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information request if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the Practice; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

• **Coroners, Medical Examiners, and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.

• **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

#### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of the last revision and effective date. In addition, each time you visit the practice for treatment or health care service you may request a copy of the current notice in effect.

#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of Health and Human Service. To file a complaint with the Practice, contact our safety officer who will direct you on how to file a complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you. The safety officer can be reached at this number (865) 588-2753.

**You will not be penalized for filing a complaint.**

#### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons, covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

#### **PATIENT RIGHTS THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.**

You have the following rights regarding medical information we maintain about you:

• **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.



**Jane R. Conley, MD**  
Board Certified Specialists in  
Allergy, Asthma & Immunology

**Sangeetha M. Kodoth, MD**  
Board Certified Specialist in  
Allergy, Asthma & Immunology

## OFFICE DIRECTIONS

IF YOU ARE LOST ON THE WAY TO ANY OF OUR OFFICES, PLEASE CALL THE MAIN OFFICE NUMBER FOR HELP

**865-588-2753**

**Main Office: 1346 Dowell Springs Blvd, Knoxville, TN 37909 (Bearden/Middlebrook Area)**

### **From Interstate-40 Westbound:**

- Take exit **383** for Papermill Dr. It is easier if you get into the left lane of the exit ramp.
- Once you are on the exit ramp, it will split into two parts- Papermill and Weisgarber.
- Bear to your left, following the signs for Weisgarber Rd.
- Take the exit ramp for Weisgarber Rd. At the bottom of the ramp (at the light) turn right onto Weisgarber.
- Turn left at the third traffic light onto Middlebrook Pike.
- Go straight through one traffic light (at Old Weisgarber Rd.)
- After the light, take the first right into "Dowell Springs". There are two stone walls on both sides of the entrance with "Dowell Springs" signs.
- Take the Second right onto Lonas Springs Rd and then an immediate right into our parking lot and our entrance will be directly in front of you. .

### **From Interstate-40 Eastbound:**

- Take the Papermill Exit.
- Turn right at the stop light at the bottom of the exit ramp onto Papermill Dr.
- Turn right at the next stop light onto Weisgarber Rd.
- Turn left at the fourth traffic light onto Middlebrook Pike.
- Go straight through one traffic light (at Old Weisgarber Rd.)
- After the light, take the first right into "Dowell Springs". There are two stone walls on both sides of the entrance with "Dowell Springs" signs.
- Take the Second right onto Lonas Springs Rd and then an immediate right into our parking lot and our entrance will be directly in front of you.

**Lenoir City Office: 460 Medical Park Dr, Suite 108, Lenoir City, TN 37772**

### **From Knoxville:**

- Take 40 West toward I-75 South
- Continue to follow I-75 South.
- Take Exit #81/ for US-321 toward Lenoir City/Oak Ridge
- Turn Left onto US-321 South
- Turn Left at Medical Park Dr. (just past the hospital but before the Wal-Mart)
- Turn right to the 460 Building and we are located inside the Pediatric Consultant office.

### **From Athens:**

- Take I-75 North.
- Take Exit #81/ for US-321 toward Lenoir City/Oak Ridge
- Turn Right onto US-321 South (signs for Lenoir City)
- Turn Left at Medical Park Dr. (just past the hospital but before the Wal-Mart)
- Turn right to the 460 Building and we are located inside the Pediatric Consultant office

**Please see reverse side for directions to the Tennova South Office and Morristown Office**

**Jane R. Conley, MD**  
Board Certified Specialists in  
Allergy, Asthma & Immunology

**Sangeetha M. Kodoth, MD**  
Board Certified Specialist in  
Allergy, Asthma & Immunology

## **OFFICE DIRECTIONS**

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865-588-2753**

### **Tennova South Office: 7323 Chapman Hwy, Knoxville, TN 37920**

#### **From Interstate 40 Eastbound:**

- Take I-40 East toward I-75 North
- Take Exit #388 for US-441 S/Henley Street toward downtown.
- Keep left at the fork to continue toward TN-71 S/US-441 S/Henley St and merge onto TN-71 S/US-441 S/Henley St.
- Cross the Henley Street Bridge and continue approximately 6 miles on Chapman Hwy (TN-71 S/US- 441)
- Turn right into the Chapman Plaza to arrive at Tennova South.
- Enter the front doors and we are located in the suites to your right.

#### **From the Seymour Area:**

- Take Chapman Hwy (TN-71 N/US-441 N)
- Turn left into the Chapman Plaza to arrive at Tennova South.
- Enter the front doors and we are located in the suites to your right

### **Morristown Office: 850 W. 3<sup>rd</sup> North Street, Morristown, TN 37814**

#### **From Jefferson City:**

- Follow Highway 11-E to Morristown (Andrew Johnson Highway).
- Continue through Morristown, passing Lowe's on your left and Pizza Hut on your right.
- Soon after Pizza Hut, turn left onto Fairmont Street.
- Take the first right onto W. 3<sup>rd</sup> North Street
- Go straight through the 4-way stop (at High Street-there is a floral shop on the corner).
- Turn left into the parking lot of the large office building on your left.
- We are on the upper side of the building inside Dr. Walker & Lowry's office (East TN Health Center).

#### **From Interstate-81:**

- Take the Lowland (Morristown) Exit (Route 160) and turn toward Morristown.  
(If you are on I-81 South, you will be turning right. If you are on I-81 North, you will be turning left.)
- Pass under Route 25-E, continuing on Route 160.
- Take the Cumberland St. Exit (Route 343) and go right, towards Morristown.
- Go straight through the light at West Morris Boulevard (Also called 11-E, in downtown Morristown).
- Turn left on W. 1<sup>st</sup> North (same as Andrew Johnson Hwy- the main road that goes through Morristown).
- Turn right on North High Street
- Turn right on West 3<sup>rd</sup> North.
- Turn left into the parking lot of the large office building on your left.
- We are on the upper side of the building inside Dr. Walker & Lowry's office (East TN Health Center).

**Please see other side for directions to the Main Office and Lenoir City Office**