Allergy, Asthma & Immunology Center, P.C.

Vital Prospects Clinical Research Institute, P.C.

Iftikhar Hussain, MD

Registration Form & Policies

Patient Name (Last, First, MI): _____ DOB: _____

Social Security #: _____ PCP: _____ Referring Provider: _____

Patient Address: _____ APT: _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Gender: ☐ Male ☐ Female

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic or Latino ☐ Refuse to Report ☐ Other: _____

Race: ☐ White ☐ Black or African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Other: _____

Insurance Information

Primary Insurance: _____ Member/Policy Number: _____

Group Name/Number: _____ Policy Holder Relationship: _____

Policy Holder: _____ DOB: _____ Social Security #: _____

Phone: _____ Policy Holder's Employer & Phone: _____

Secondary Insurance: _____ Member/Policy Number: _____

Group Name/Number: _____ Policy Holder Relationship: _____

Policy Holder: _____ DOB: _____ Social Security #: _____

Phone: _____ Policy Holder's Employer & Phone: _____

IF A MINOR, PLEASE COMPLETE BELOW: Parent, legal or custodial guardian **(where the child lives)**

Relationship: _____ Name: _____ DOB: _____

Soc Sec #: _____ Email: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Signature

PRINTED Name of Person Completing This Form

Patient (Parent/Guardian) Signature

Relationship to Patient

Date

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Name: _____ Age: _____ Date: _____

Chief Complaint:

Please list adverse reactions to any drugs, foods, or insect stings:

Current Medications:

Medication	Dose	Frequency	Indication	Start Date	Stop Date

Medical History (Diagnosis):

Surgical History (Procedure):

Any Communicable Diseases? ☐ **Yes** ☐ **No** **If Yes:** Check Box: ☐ HIV ☐ AIDS ☐ HEP C

Other: _____

Family Health History: **Place a check for your responses**

Family Member	Allergy/Sinus	Eczema	Asthma	Heart Disease	Unknown
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Sister/Brother	☐	☐	☐	☐	☐
Grandmother/Grandfather	☐	☐	☐	☐	☐
Aunt/Uncle	☐	☐	☐	☐	☐

Reviewed by: _____ Patient DOB: _____

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Name: _____

Social History (Please Check)

Smoker? ☐ Yes ☐ No **If Yes:** How many per day? _____

Date started? _____ Date stopped? _____

Alcohol Consumption? ☐ Yes ☐ No Caffeine Intake? ☐ Yes ☐ No

Recreational Drug? ☐ Yes ☐ No Exercise? ☐ Yes ☐ No

Home Smoke Detector? ☐ Yes ☐ No Humidifier in Home? ☐ Yes ☐ No

Type of residence? ☐ House ☐ Condo ☐ Apartment ☐ Trailer

What is the age of your home? _____

Type of flooring at home? ☐ Carpet ☐ Wood ☐ Area Rugs

Any pets at home with fur or feathers? ☐ Yes ☐ No

If Yes: What Kind? _____

How Many? _____

Travel outside the United States? ☐ Yes ☐ No **If Yes:** Where?

Sexually Active? ☐ Yes ☐ No

Review of Symptoms (Please Check)

Allergy	**General**	**ENT**	**Respiratory**
☐ Runny Nose	☐ Weight Gain	☐ Cold	☐ Chest Pain
☐ Scratchy Throat	☐ Weight Loss	☐ Cough	☐ Cough
☐ Itchy Eyes	☐ Weakness	☐ Nose Bleeds	☐ Wheezing
☐ Sneezing	☐ Loss of Appetite	☐ Hearing Loss	☐ Shortness of Breath
☐ Ear Fullness	☐ Fatigue	☐ Change in Voice	☐ Chest Congestion
☐ Sinus Congestion	☐ Fever	☐ Sore Throat	☐ Dyspnea
☐ Sinus Drainage	☐ Breastfeeding	☐ Ringing in Ears	☐ Sleep Disturbance
☐ Itchy Nose	☐ Feeding	☐ Sinus Pain/Headaches	☐ Difficulty Breathing Lying Down

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Name: _____

Ophthalmology

- ☐ Eye Irritation
- ☐ Redness
- ☐ Dryness
- ☐ Eye Drainage
- ☐ Blurred Vision
- ☐ Diminished Vision
- ☐ Loss of Vision
- ☐ Seasonal Eye Symptoms

Endocrinology

- ☐ Fatigue
- ☐ Excessive Thirst
- ☐ Weight Loss
- ☐ Sleep Disturbance
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Diabetes
- ☐ Thyroid Disorder

Cardiology

- ☐ Dizziness
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Rapid Heart Rate
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Leg Edema
- ☐ Leg Pain

Gastroenterology

- ☐ Nausea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Vomiting
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Constipation

Urology

- ☐ Recurring UTI
- ☐ Blood in Urine
- ☐ Difficult Urinating
- ☐ Frequent Urination
- ☐ Nocturia

Dermatology

- ☐ Eczema
- ☐ Rash
- ☐ Mole
- ☐ Lumps
- ☐ Hives
- ☐ Skin Cancer
- ☐ Acne

Neurology

- ☐ Headache
- ☐ Seizures
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Memory Changes
- ☐ Tingling/Numbness
- ☐ Dizziness

Hematology

- ☐ Loss of Appetite
- ☐ Varicose Veins
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Other:

Musculoskeletal

- ☐ Joint Stiffness
- ☐ Leg Cramps
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Sciatica
- ☐ Fracture
- ☐ Carpal Tunnel
- ☐ Osteoporosis Treatment

Psychology

- ☐ Depression
- ☐ Anxiety
- ☐ High Stress
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts
- ☐ Abuse
- ☐ Eating Disorder
- ☐ Agitation/Irritability

Reviewed by: _____ Patient DOB: _____

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HIPAA Right of Access Form for Family Member/Friend

AFTER REVIEWING EACH SECTION BELOW, PLEASE INITIAL

_____ (Initial) **AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION:**
I authorize AAIC to release my medical information and/or individually identifiable health information to me(us) or my(our) duly authorized representative (as noted above), representatives of local, state, or federal agencies and insurance companies or other organizations or entities as may be required to be permitted under federal or state law or for review or payment of claims. I further authorize AAIC to release such information to physicians, hospitals or healthcare providers in order to treat me or to review my treatment. I understand that the specific information to be released may include, but is not limited to, history, diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I also understand I may revoke this authorization with a written and dated notice except to the extent that disclosure of information has been made prior of receipt of revocation.

_____ (Initial) **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONDITIONS OF TREATMENT**
The notice of Privacy practices provides specific information and complete description of how my personal health information may be used and disclosed. I(we) acknowledge that upon my request I(we) have been provided and have reviewed the Notice of Privacy Practices (dated June 1, 2026) and Conditions of Treatment. I(we) understand that as part of my healthcare, AAIC maintains health records describing my health symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand this information is used to plan my care and treatment and to bill for services provided. It is also used to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals as required or permitted by law without my consent.

_____ (Initial) **AUTHORIZATION TO CONTACT PATIENT OR ACCOUNT REPRESENTATIVE:** I (we) hereby authorize AAIC physicians and staff to leave detailed information by mail, phone, text or email regarding lab results, clinical information and account balance(s).

Please list below any person(s) to whom we may inquire and/or inform about your general medical information, conditions or diagnosis. (These will be listed as Emergency Contacts)

Name: _____ Relationship: _____ Cell: _____

Information to be released to above (please initial ONE)

_____ Complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment & billing)

_____ Complete health record as above, EXCEPT mental health, communicable diseases, alcohol/drug abuse treatment

Name: _____ Relationship: _____ Cell: _____

Information to be released to above (please check)

☐ Complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment & billing)

☐ Complete health record as above (EXCEPT mental health, communicable diseases, alcohol/drug abuse treatment)

PRINTED Name of Person Completing Form | **Patient (Parent/Guardian) Signature**

Relationship to Patient | **Date**

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GENERAL DISCLOSURE AND INFORMED CONSENT FOR MEDICAL & DIAGNOSTIC PROCEDURES

TO THE PATIENT: You have the right, as a patient, parent, or legal guardian, to be informed about the condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether to undergo the procedure after knowing the risks and hazards involved. This is simply an effort to make you better informed so you may give or withhold your consent to the procedures recommended to you.

I am of sound mental and physical condition and can give informed consent. I acknowledge that I am fully aware of the care, treatment, and/or services that I am going to receive that is subject of this form. I consent to Allergy, Asthma and Immunology providers and support staff to treat my conditions involving any organ system of the body, but primarily nasal allergy, eye allergies, asthma, eczema, urticaria, angioedema, headaches, and gastrointestinal symptoms.

I understand that the following medical and/or diagnostic procedures may be necessary for me and I voluntarily consent and authorize these procedures as deemed necessary upon examination:

1) Skin testing (Percutaneous and Intradermal)
2) Patch tests
3) Immunotherapy
4) Spirometry
5) Blood or Imaging studies (X-rays)
6) Oral challenges or desensitization
7) Rhinoscopy
8) Punch Biopsy
9) Topical anesthetics (Lidocaine and Epi)
10) Injections (steroid or biologic medications)
11) Nebulized medications
12) Anaphylactic measures

I understand that my physician may discover different conditions which may require additional procedures than those planned. I realize that common to medical and/or diagnostic procedures is the potential for infection, hemorrhage, syncope, allergic reactions and in very rare instances, even death due to severe systemic reaction. I authorize my physician and such associates, technical assistants and other health care providers to perform such other procedures, that are advisable in their professional judgment which might include escalation of care including calling paramedics. I understand that no warranty or guarantee has been made to me as to the result of any procedure or cure of any condition. Just as there may be risks and hazards in continuing my present condition with or without treatment or procedure(s), there are also risks and hazards related to the performance of the medical and/or diagnostic procedures which may be planned for me.

For example:
For patients that start immunotherapy **(allergy injections):** I understand that immunotherapy may result in complications of anaphylaxis and even death. The American Academy of Allergy, Asthma and Immunology recommends that immunotherapy be given under a physician's supervision. This practice believes this position is medically appropriate and that you should always obtain your injection by trained personnel, either in our office or another medical setting. Thus, I understand that the immunotherapy is to be administered under a physician's supervision. Furthermore, I understand that it is required for me to wait **AT LEAST 20-30 MINUTES** after each allergy injection before leaving the physician's office. If I leave early, I understand that it is against medical advice and will hold my treating physician and staff at AAIC free of any liability.

I have received sufficient information to give this informed general consent to treat. I acknowledge that this disclosure and informed consent has been fully explained to me, that I have read it or have had it read to me and that I understand its contents.

Patient Name: _____

Patient Signature: _____ Date: _____

Name of Legal Guardian (if minor): _____

Signature of Legal Guardian: _____ Date: _____

Allergy, Asthma & Immunology Center, P.C.

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2026 FINANCIAL POLICY

Patient Name: _____

Allergy, Asthma & Immunology Center, P.C. is extremely pleased to provide care to you and your family. The following outlines our clinic's financial policy for 2026.

We must emphasize that as a medical practice, our relationship is between you and AAIC providers, not the insurance company. While filing insurance claims is a courtesy that we extend to our patients, it is ultimately your responsibility to understand your policy benefits. AAIC contracts with most major insurance companies. **It is your responsibility to verify AAIC is in network with your insurance carrier.** ***Patients are responsible for any portion of charges deemed non-covered or noted as "patient responsibility."*** Services listed as "covered" by your plan are still subject to the patient financial liability for deductibles, co-insurance, and co-payments (as outlined per your plan].

AAIC is an independent private practice clinic and strongly recommends that patients checkin advance 1] insurance benefits and exclusions and 2] financial responsibilities they may have with non-AAIC entities such as outside labs, clinics, pharmacies, or other physicians.

Once the record of insurance has been established it will be your responsibility to notify us of any changes. If you do not, you will be fully responsible for any amount rejected by insurance. Benefits will be verified prior to appointment, and any deductible remaining will be due at time of service.

If you have no insurance $290 is expected at the time of service for new patients; $218 is expected at the time of service for established patients. The business office is available to assist with a formal payment plan for any remaining balance.

All co-payments are due at the time of service, including patients who have a co-pay and/or co-insurance associated with administering injections. If your insurance provider requires a referral, such as (but not limited to] Tricare Prime, VA, Sooner Care, My BLUEHMO or Generations Global Health, **you** are responsible for obtaining a referral to our office from your primary care physician. **This must be received by AAIC no later than 48 hours prior to the appointment. We follow guidelines set forth by these plans and services cannot be rendered if not authorized. Referrals should be faxed to 918- 392-4551.**

Once your claim has been processed you will receive a statement of patient responsibility for the services provided. Payment in full is expected upon receipt of statement(s]. AAIC accepts payment by cash (in office only], check or credit card including Amex®/ Discover®/ MasterCard®/Visa®.

Payments can be made by phone (918] 392-4550 or mailed to:

AAIC
7307 S. Yale Ave., Ste 200
Tulsa OK 74136-8303

If your insurance company does not respond within 30 days after your claim is filed, payment will become your responsibility. Any amount remaining after insurance has been paid or denied will be expected to be paid upon receipt of your statement unless other arrangements are made with our billing department. If you are unable to pay your balance in full upon receipt of your statement, please call to speak with our billing staff to set up a monthly payment plan.

7307 S. Yale Ave., Ste. 200 • Tulsa, Oklahoma 74136-8303 • Phone (918) 392-4550 • Fax (918) 392-4551

2026 FINANCIAL POLICY

(Continued)

Patient Name: _____

Patients with unpaid delinquent balances after 90 days will be sent to a collection agency and patients are responsible for up to ***70% collection agency fees*** *in addition to the account balance.* ***All unpaid balances are subject to the Small Claims Court.*** *Satisfactory payment arrangements or account balance settlement are required before receiving any future services.*

A $50 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pay cash, money order or credit card for services.

Please be considerate of other patients when cancelling or rescheduling an appointment. A no show fee of $50 for an office visit could be charged if not cancelled or rescheduled at least 24 hours in advance. Anyone who cancels or reschedules ***within*** the 24-hour period or after could result in a $25 Late Cancellation Fee. For your convenience you can notify us by calling (918) 392-4550.

We are committed to providing our patients with quality care. By informing you of our expectations, we hope to alleviate any misunderstandings concerning your financial responsibility. Should you have questions about your account, please contact our office at (918) 392-4550 and ask for the billing department.

I authorize release of any information necessary to process claims and direct payments to Allergy, Asthma & Immunology Center, P.C. I understand that I am responsible for all charges, regardless of insurance coverage. If the patient is a minor, the financial responsibility lies with the parent or guardian bringing the child for treatment.

I understand and agree to the terms of this financial policy.

_____ _____

Signature of Patient or Responsible Party Relationship to Patient

Date: _____

7307 S. Yale Ave., Ste. 200 • Tulsa, Oklahoma 74136-8303 • Phone (918) 392-4550 • Fax (918) 392-4551

Allergy, Asthma & Immunology Center, P.C.
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2026 No-Show, Co-Pay and Late Cancellation Policy

Patient Name: _____

All office visit and shot co-pays will be due at the time of the service.

Please be considerate of other patients when cancelling or rescheduling an appointment. Any appointment not cancelled or rescheduled at least 24 hours in advance could be charged a **$50 No-Show Fee.** This fee must be paid in full immediately.

The No-Show Fee is the responsibility of the patient. No insurance will pay for this fee.

Any appointment cancelled or rescheduled within the 24-hour period prior to, or after, your current scheduled appointment could result in a **$25 Late Cancellation Fee.**

I understand and agree to the terms of this financial policy.

_____
Signature of Patient or Responsible Party

_____
Relationship to Patient

_____
Date