Allergy & Asthma Consultants, L.L.P.
800 W.34th Street • Suite 201 • Austin, Texas 78705
Office (512) 454-5821 • Fax (512) 459-9137

MRN___________
DR____________
ENTERED______

PATIENT INFORMATION

Patient Information (Name as it appears on insurance card)

Last Name First Name Middle Initial

Street Address Apt # City State Zip Code

Home Phone: ( ) __________ Daytime/Work Phone ( ) __________

Cell Phone: ( ) __________ Social Security # __________

Date of Birth ____/____/____
MM/DD/YYYY

Married ❒ Divorced ❒ Minor (under age 18) ❒
Single ❒ Widowed ❒

Male ❒ Female ❒

Mother

Father

Employment Information

Employer Name

Street Address City State Zip Code

Full Time ❒ Part Time ❒ Retired ❒ Temporary ❒ Self-employed ❒ Student ❒

Emergency Contact

Name Relationship

Home Phone ( ) __________ Cell Phone ( ) __________

Insurance Information: Primary Insured or Responsible Party

Last Name First Name Middle Initial

Date of Birth ____/____/____ Social Security # __________
MM/DD/YYYY

Primary Insurance Company **Secondary Insurance Company**

Name Name

Primary Care Physician

Name City State

Referred by

Physician __________ Friend ❒ Newspaper Ad ❒ Yellow Pages ❒ Insurance ❒
Name Internet ❒ Other __________

PLEASE READ EACH STATEMENT BELOW, THEN SIGN AND DATE ACCORDINGLY.

PATIENT LABEL

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Assignment of Benefits

In the event that the patient or insured does not pay for services rendered, I hereby give authorization for payment of insurance benefits to be made directly to: **Dr. T.S. Painter, Jr. ❒, Dr. Edward J. Peters ❒, Dr. Maria G. Gutierrez ❒, Dr. Paul G. Vigo ❒, Dr. John P. Dice ❒** and any assisting providers, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement shall be valid as the original.

Signature ______________________ Date ______________

Print Name ______________________

Financial Policy

I understand that Allergy & Asthma Consultants LLP will file with my primary insurance company charges that incur on my initial, testing and future visits. There will be no fee for filing these charges. I will promptly inform the office of a change in my medical insurance. I understand that I am responsible for the co-pay amount at each office visit as directed by my insurance. I also agree to pay any remaining collectible balances as governed by my insurance plan. Any over payment resulting from payments by me and/or the insurance company will be promptly refunded. I understand that my release of direct payment of insurance benefits does not release me from responsibility for full payment for services (if unpaid by my insurance) rendered by Allergy & Asthma Consultants LLP. I understand that payment is expected at the time of service.

Signature ______________________ Date ______________

Print Name ______________________

Release of Medical Information and Patient Consent Agreement

I hereby consent to the use or disclosure of my "protected health information" as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Allergy & Asthma Consultants, L.L.P.

Signature ______________________ Date ______________

Print Name ______________________

Consent to Treatment

I understand that the diagnostic procedure(s) prescribed by my physician will be performed by Allergy & Asthma Consultants LLP and I do hereby authorize and consent to such treatment and procedures. I understand that if the patient is a minor (under age 18) he or she must be accompanied by a legal guardian at the time of treatment or must present a written letter signed by a legal guardian authorizing Allergy & Asthma Consultants LLP to provide treatment to the patient. I further certify that no guarantee of assurance has been made as to the results, which may be obtained.

Signature ______________________ Date ______________

Print Name ______________________

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I authorize this facility to speak to the following family members or my personal representative regarding:

☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

☐ Only the following types of information:

____

____

The above medical information shall only be released to the following persons:

Family Member/Personal Representative	Relationship to Patient
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

It is the policy of Allergy & Asthma Consultants, L.L.P. to leave messages for patients regarding lab/x-ray/CT results, appointments and when returning calls. Please list the authorized phone number(s) where a confidential message can be left for the patient.

Primary Message Phone No.: (______) ______________ Secondary Message Phone No.: (______) ______________

I understand that I may terminate this Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one):

☐ Until revoked in writing

☐ Until ________________ , 20 ____

I know that I am entitled to receive a copy of this agreement.

______________________________________ ______________________________
Patient Name Date

____
Patient Signature

PATIENT LABEL