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 ❐
Single ❐ Widowed ❐

Male ❐ Female ❐

Minor (under age 18) ❐
Guardian & Relationship: ____________________

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 ______/______/______
MM/DD/YYYY

Social Security #____________________

Primary Insurance Company

____
Name

Secondary Insurance Company

____
Name

Primary Care Physician

____
Name City State

Referred by

Physician ______________________________
Name

Friend ❐ Newspaper Ad ❐ Yellow Pages ❐ Insurance ❐
Internet ❐ Other ____________________

My Documents/ Forms/New Patient Information Form
Revised 06/22/07

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

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 ❒,** or **Dr Bernard L Crosby ❒,** 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 ______________

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 ______________

Release of Medical Information

I hereby authorize Allergy & Asthma Consultants LLP to release any medical information regarding the services performed to my personal (primary care) physician, insurance company, or employer (in the event of a Worker's Compensation injury).

Signature ______________________ Date ______________

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 ______________

PATIENT LABEL