Allergy & Asthma Centres OF THE METROPLEX

Date: _____ PID: _____

Patient Name: _____ Date of Birth _____ Sex: (Circle) __M__F__
First Middle Last

Full Home Address: _____

Home Phone: _____ Cell Phone: _____

Marital Status: (Circle)_____Single_____Married_____Divorced_____Widowed_____Separated_____Other_____

Place of Employment: _____ Work Phone: _____

Patient Social Security #: _____ Driver's License Number (Parent's if Minor): _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Responsible Party Information

Responsible Party Name: _____ Date of Birth: _____
First Middle Last

Full Home Address: _____

Social Security #: _____ Place of Employment: _____ Phone: _____

Insurance Information

Primary Insurance Company: _____ Insurance ID Number: _____ Group: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Social Security Number: _____ Employer: _____

Secondary Insurance Information ☐ N/A

Name of Insurance Company: _____ Insurance ID Number: _____ Group: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: _____ Social Security Number: _____ Employer: _____

Authorization to Treat Minors Consent ☐ N/A ☐ I do not wish to Authorize Minor Consent

I, _____, the parent or legal guardian of the above patient, a minor, do hereby authorize *Allergy & Asthma Centres of the Metroplex* and its personnel to deliver routine or emergency medical treatment and services to my child as deemed necessary or advisable in my absence or in the absence of any other directly related family member. **I understand that the above minor patient must still have an adult present over the age of 18 unless otherwise authorized by the Responsible Physician of *Allergy & Asthma Centres of the Metroplex*.**

Limitations: Please identify any specific limitations on the types of medical services for which this authorization is given and any unauthorized adults who may not make emergency decisions as deemed necessary if you or any other parent/ guardian cannot be contacted (If none, state "none"):

_____

Parental Contact Information for emergencies/ questions regarding treatment of the minor child:

Parent's Name: _____ Cell Phone: _____ Work Phone: _____

Parent's Name: _____ Cell Phone: _____ Work Phone: _____

I hereby indemnify and hold harmless Allergy & Asthma Centres of the Metroplex and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs, and assigns from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization shall be effective from the date it is executed until it is revoked in writing to the Practice Manager of Allergy & Asthma Centres of the Metroplex.

Only one parent signature is required.

_____ _____ _____ _____

Signature of Parent or Guardian Date Signature of Parent or Guardian Date

Allergy & Asthma Centres
OF THE METROPLEX

Stephen Apaliski, MD

Name: _____ Date of Birth: _____

Visit Date: _____ Referring Physician: _____

Past Medical History (list your diagnosed medical problems such as high blood pressure, heart disease, cancer, etc.)

1. _____ 3. _____
2. _____ 4. _____

Birth History (For Pediatric Patients):

1. Please circle, birth was: **On time** or **Premature** If so, how many weeks? _____
2. Please list any other complications experienced since delivery or after birth: _____
3. Growing/gaining weight/ developing normally since birth? _____

Past Surgical History, Hospitalizations, Emergency Room Visits- Please list approximate date each event occurred:

1. _____ 3. _____
2. _____ 4. _____

Family History Please list medical problems experienced by patient's family members (Include allergy/asthma related problems)

1. Mother: _____ 3. Sister: _____
2. Father: _____ 4. Brother: _____

Allergy History Are you allergic to any **food, medicine, chemicals, latex or insects?** ☐ **Yes** ☐ **No**
If yes, please list: _____

Social History Please answer the following questions:

1. Do you currently smoke or have you smoked in the past? ☐ **Yes** ☐ **No**
If yes, how much for how long? _____
2. Do you live with someone that smokes? ☐ **Yes** ☐ **No**
If yes, do they smoke inside? _____
3. Do you have carpet in your home? ☐ **Yes** ☐ **No**
4. Do you drink alcohol? ☐ **Yes** ☐ **No**
If yes, how much per week? _____
5. Do you exercise regularly? ☐ **Yes** ☐ **No**
6. Please list pets you currently own: _____ **Indoor or outdoor?** _____
7. Are you exposed to mold, fumes, chemicals? ☐ **Yes** ☐ **No** **Where/What?** _____
8. What is your current occupation? _____

Current Medications Please list **ALL OVER THE COUNTER AND PRESCRIPTION MEDICINE AND HERBAL REMEDIES:**

_____ _____ _____
_____ _____ _____
_____ _____ _____

Review of Symptoms Please circle any sign, symptoms or conditions that you are CURRENTLY experiencing:

Respiratory:	short of breath	wheeze	cough	tight chest	night time cough
Nose:	runny	stuffy	itchy	sneeze	loss of smell
Eyes:	itchy	watery	red	blurry	frequent infections
Skin:	dry	itchy	swelling	rash	hives
Infection:	acute sinusitis	recurrent sinusitis	bronchitis	pneumonia	other

Allergy & Asthma Centres
OF THE METROPLEX

PATIENT PORTAL ANNOUNCEMENT

Allergy & Asthma Centres of the Metroplex is pleased to announce our secure **Patient Portal** via our electronic health record system. The Patient Portal will ease communication between you and our office, providing convenient and efficient access to various services including messaging, refill requests, appointment reminders, and document exchange.

Please fill out the information below in order to receive your patient portal access email which will include your sign-on information.

Guarantor of Insurance Full Name*: _____ Date-of-Birth: _____

Cellphone for text reminders (optional): _____

Email Address* (**required for login**): _____

Please list all patients associated with this guarantor that you wish to have portal access:

Patient Full Name: _____ Date-of-Birth: _____

Patient Full Name: _____ Date-of-Birth: _____

Patient Full Name: _____ Date-of-Birth: _____

Patient Full Name: _____ Date-of-Birth: _____

(NOTE: Must provide e-mail to enable access. User ID will be your e-mail address**)**

☐ Check to Enable Access to Patient Portal ☐ Check to Opt-Out of Patient Portal

Patient/Guardian Signature: _____ Date: _____

Please contact our office if you have any questions in regards to our Patient Portal at (817) 460-7447.

Sincerely,

Allergy & Asthma Centres of the Metroplex Management

ALLERGY & ASTHMA CENTRES OF THE METROPLEX

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) to perform and/or order another person to perform all exams, test, procedures, and other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to the Allergy & Asthma Centres of the Metroplex unless revoked by me orally or in writing.

_____ _____

Date Patient/Legal Representative

AUTHORIZATION FOR RELEASE OF INFORMATION

"I hereby authorize the release/obtaining of all medical records to and from the referring and family physician and related laboratory and radiology units as well as all records necessary for processing of insurance claims."

_____ _____

Date Patient/Legal Representative

ASSIGNMENT OF BENEFITS

"I authorize payment of any medical benefits from my insurance company or managed care plan to Allergy & Asthma Centres of the Metroplex for services rendered. **I understand that benefits quoted by my insurance company are not a guarantee of benefits until the actual claims are processed.** I agree to be responsible for charges not covered by my insurance company including pre-existing conditions and any copayments or deductibles required by my managed care plan, for which service has been rendered."

_____ _____

Date Patient/Legal Representative

NOTICE!!

I understand that the Allergy & Asthma Centres of the Metroplex does not accept **MEDICARE, TRICARE** or **MEDICAID**. I agree to be responsible for any services that are rendered to me under **MEDICARE, TRICARE** or **MEDICAID**.

_____ _____

Date Patient/Legal Representative

Allergy & Asthma Centres
OF THE METROPLEX

Financial Policy

Payment is due at the time services are rendered. Allergy and Asthma Centres of the Metroplex requires all patients to pay their deductible, copay and/or coinsurance or 'self-pay' payment at the beginning of each visit by debit card (EFT), credit card, CareCredit, cash or check.

As a courtesy, we verify your medical benefits with your insurance company, however, a quote of benefits is not a guarantee of benefits or payment. If your claim processes differently from the benefits that were quoted, the insurance company will not honor the benefit quote we received.

At the conclusion of your visit with us, you may be billed for any outstanding balances. If there is a credit, you will be provided a refund immediately. You are responsible for all outstanding charges incurred and our verification of your insurance benefits is not a guarantee of payment.

Refund Policy

Allergy and Asthma Centres of the Metroplex has **a no refund/ no return policy** for any services that have been rendered.

RE: Antigen (Allergy Shots [SCIT]/Sublingual Immunotherapy [SLIT]): Antigen is custom made-to-order for each patient and cannot be used for any other patient or re-stocked. You may choose to cancel a consent for antigen in writing and issued a refund in the full amount ***if*** the antigen ***has not*** been compounded. Once antigen has been compounded it is a service that has been rendered and payment will not be refunded.

In the case of an overpayment, if the payment has not been posted to the account, a refund will be provided promptly. If the payment has been posted to the account and all pending claims have processed, the patient may request a refund in writing.

Allergy and Asthma Centres of the Metroplex has informed me (the patient or responsible guardian of the patient) that all payments will be collected on the same day services are rendered. I recognize that the acceptance of my insurance does not place all financial responsibilities onto this practice, and I will be held accountable for any unpaid balances by my plan. I understand that this practice has a no refund/ no return policy for any services that have been rendered and I must cancel my consent for antigen in writing before it has been compounded to ensure a full refund. I acknowledge and agree to these terms.

_____

Print Patient Name **Date of Birth**

_____

Signature of Patient, Guardian or Authorized Representative **Date**

Allergy & Asthma Centres
OF THE METROPLEX

Non-Covered Services or Limitations on Services

Recent changes in insurance regulations and provider agreements may have limited certain services or deemed certain services 'non-covered' that are provided by Allergy and Asthma Centres of the Metroplex—these services could include more than those specifically mentioned below depending on your plan. Since we believe each scheduled visit and service in our office is medically necessary, attempts will be made to collect payments from insurance companies. In the event the payment is denied, you agree to be responsible for paying these rendered services.

RE: Sublingual Immunotherapy (SLIT): SLIT orders require payment upfront before services are rendered due to shelf-life and the length of time it takes claims to process. If coverage for this service is denied by the insurance company you have no additional financial responsibility for the antigen. However, if the payment is approved and processed, the patient will be issued a refund or adjusted refund according to the amount the insurance has agreed responsibility for.

Administrative fees not covered by insurance:
FMLA/Disability Forms: $20.00 per service.
School Forms: $15.00 per school year, per family.

Insurance regulations and our provider agreements require that you sign the agreement below:

Allergy and Asthma Centres of the Metroplex has informed me (the patient or responsible guardian of the patient) that payment for services rendered may be denied by insurance for the reasons above. I agree to be personally responsible for payment in the event that my insurance company denies payment and responsibility.

_____

Print Patient Name **Date of Birth**

_____

Signature of Patient, Guardian or Authorized Representative **Date**

Allergy & Asthma Centres OF THE METROPLEX

PID # _____

Authorization Form for Release of Protected Health Information

By signing this form, I authorize you to use and disclose protected health information described below.

Release my protected health information to the following person(s)/entity:

_____

_____

☐ Initial here if you **do not** choose to release your protected information to anyone.

If you choose to release information to the specified person (s) above, indicate which health information you may release subject to this authorization (i.e. office visit notes, skin test, billing, etc):

_____

_____

☐ Initial here to release all medical and personal information.

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

☐ Initial here for indefinite authorization.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following address: Allergy & Asthma Centres of the Metroplex, 5421 Matlock Rd., Arlington, TX 76018- Attn: Privacy Officer- Fax 817-461-0809

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that this information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Signature of Patient or Parent/Legal Guardian Today's date

_____ _____

Print Name of Patient or Parent/ Legal Guardian **Patient Date of Birth**