ALLERGY & ASTHMA
CENTER OF TEXAS

Today's Date: ____/____/____

Health Information Sheet

Patient's Name: _____ Date of Birth: _____ Age: _____

Address: _____ Phone Number: _____

Race: _____ Primary Care Physician: _____

How were you referred? _____

Pharmacy name: _____ Location (City and Cross Streets): _____

Please describe the reason for the visit today: _____

_____

_____

Past Medical History – Please list **ALL** past medical problems:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Surgical History – Please list all past surgeries and the date that they were performed:

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

Allergy History – Are you allergic to any **food, medicine, chemical, latex, insects, and/or other?** YES ☐ NO ☐

If yes, please list: _____

_____

Family History – Please list medical problems experienced by patient's family members: (Include allergy/asthma/eczema/immune problems)

Mother's Side: _____

Father's Side: _____

Social History – Please answer the following questions:

Do you have pets? NO ☐ YES ☐ If yes, what type and how many? _____

Do you currently smoke or have you smoked in the past? NO ☐ YES ☐ If yes, how long? _____

Do you consume alcohol? NO ☐ YES ☐ If yes, how many drinks per week? _____

Do you exercise? NO ☐ YES ☐ If yes, what type of exercise? _____ How often? _____

Are you exposed to mold/fumes/strong odors/chemicals? NO ☐ YES ☐ If yes, where/what? _____

Review of Systems – Please circle any signs/symptoms/conditions that you currently experience:

Chest:	fast heart rate	palpitations				
Constitutional:	chills	fatigue	fever	night sweats		
Ears:	discharge	ear congestion	ear itching	earache	hearing loss	vertigo
Mouth and Throat:	dry mouth	sore throat				
Endocrine:	cold intolerance	heat intolerance	increased thirst	weight gain	weight loss	
Eyes:	blurred vision	itch	redness	watery		
Frequent infections:	bronchitis	ear (otitis)	pneumonia	sinusitis	skin	
GI:	diarrhea	heartburn	reflux	trouble swallowing	vomiting	
Hematology:	swollen lymph nodes	unusual bleeding	unusual bruising			
Musculoskeletal:	muscle pain	red/swollen joints	stiff/sore joints			
Neurologic:	headaches	numbness	weakness			
Nose:	congestion	itch	loss of smell	runny	sneezing	snoring
Psychology:	anxious	depressed	stressed			
Respiratory:	cough	croup	shortness of breath	tight chest	wheeze	
Sinus:	pain	post nasal drip	pressure			
Skin:	dry	hives	itch	rash	swelling	

Current Medication – Please list current medicines including **dose and directions.** (Over the Counter, prescription medicine and herbal remedies)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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Communication Authorization

Coordination of Care

If you would like Allergy & Asthma Center of Texas to share your protected health information with other health care providers, please list them below:

_____	_____	_____
Physician Name	***Specialty***	***Phone***
_____	_____	_____
Physician Name	***Specialty***	***Phone***

Emergency Contact

I hereby give permission to Allergy & Asthma Center of Texas to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

_____	_____	_____
Name	***Relationship***	***Phone***
_____	_____	_____
Name	***Relationship***	***Phone***

_____ ***I do not wish to disclose any information with anyone other than my insurance company as provided in Allergy & Asthma Center of Texas' Privacy Policy or as required by law.***

Minor Patients Only

Mother's Name: _____ ***Preferred Phone:*** _____

Father's Name: _____ ***Preferred Phone:*** _____

If you would like to designate another party to accompany patient to office visit(s), allergy injection(s), procedure(s), etc., please complete the section below:

_____	_____	_____
Name	***Relationship***	***Phone***
_____	_____	_____
Name	***Relationship***	***Phone***

_____ ***I consent and authorize the above parties to also consent to and authorize evaluation and treatment for my child when I'm not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures for my child. The duration of this consent is indefinite and continues until revoked in writing (please initial).***

_____ ***I am authorized to consent to medical treatment for this minor child (please initial).***

_____	_____
Patient Name	***Date***
_____	_____
Signature (Responsible Party)	***Printed Name (Responsible Party)***

Consent to Treat

I hereby authorize Allergy & Asthma Center of Texas and its employees and agents, including physicians, physician assistants, medical assistants, nurses and nurse practitioners to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians, etc.

_____ _____

Patient Name Date

_____

Signature (Patient, Parent/Guardian)

Minors

Minors under the age of 18 will not be seen without a parent, guardian or another designated party (Consent to treat minor form must be on file for any designated party). Appointments will be rescheduled if a parent is not present at the time of the appointment. No exceptions.

ePrescription History Consent

Our office utilizes ePrescriptions to reduce medication errors and enhance patient safety. One optional feature of this service is the ability to obtain your list of medications from your pharmacy benefit manager using the SureScripts service.

I authorize Allergy & Asthma Center of Texas to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions for the past few years.

_____ _____

Patient Name Date

_____ _____ Patient declines ePrescription history

Signature (Patient, Parent/Guardian)

Appointment Cancellations/No Shows

We reserve your appointment exclusively for you. Please understand that last minute cancellations prevent other patients from being scheduled. Allergy & Asthma Center of Texas classifies a "no show" patient as those who fail to present to the office at the time of their appointment or give 24 hours notice of cancellation or rescheduling. Note: We request AT LEAST 24 hours notice for cancellation of a regular office visit and 48 hours for cancellation or reschedule of a Procedure visit.

Cancellation/No Show Fees:

1. Follow up visits/Urgent visits/Xolair visits/New Patient visits – Cancellations or reschedules without 24 hours notice and no shows will be assessed a $50 fee.
2. RUSH/Food & Drug Challenges/Cluster – Cancellations or reschedules without 48 hours notice and no shows will be assessed a $75 fee.

We will not file this fee with your insurance company; you are responsible for the payment of this fee. Patients with three or more missed appointments may be asked to transfer their care.

Late Arrivals

We reserve the right to cancel your appointment if you present more than 10 minutes past your reserved appointment time. Patients who miss their appointment due to being late will be assessed the above missed appointment fees.

Financial Policy Agreement

The exact amount that your insurance company will pay for your claims cannot be determined with complete accuracy until the claim has been filed with your insurance company and they have processed it. We will verify services being rendered with your insurance company and give you an estimate. Any amount that your insurance company estimates is your responsibility, i.e. copay, deductible or co-insurance, and will be due at the time of service.

Payments: We accept cash, check, Visa, MasterCard, Discover and American Express.

Past Due Accounts: Any accounts over 60 days past due will be transferred to a collection agency. A $30 fee will be added to your account for the costs associated with collections. Past due balances must be paid in full before any future appointments can be scheduled.

Insurance: The terms of your insurance coverage are a contract between you and your insurance company. We call to verify your benefits as a courtesy to our patients and we do our best to provide accurate information. Final determination of payment is determined by your insurance company and should be addressed directly with them if you feel there is a discrepancy between your bill and your expected benefits.

Your doctor is contracted with most local insurance plans. It is your responsibility, however, to make sure your doctor is a contracted provider with your insurance.

Returned Check Fee: A $30 fee will be charged for any check returned by your bank.

Divorce: In case of divorce or legal separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing (presenting with the patient) treatment for a minor child will then be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Notice of Privacy Practices

You have been provided a copy of our Notice of Privacy Practices. A copy of our Notice of Privacy Practices is also posted on our website and available at our office. Our office complies with HIPAA (Health Insurance Portability and Accountability Act of 1996) and all federal and state laws governing the privacy of your information. If you have any questions regarding the information in the Notice, please contact the representative designated in the Notice.

Use of Information: By signing this form, you consent to our use and disclosure of your Protected Health Information (PHI) to carry out Treatment, Payment activities, and Healthcare Operations (TPO). You are also acknowledging receipt, understanding and agreement to our Notice of Privacy Practices. The duration of this consent is indefinite and continues until revoked in writing.

You may refuse to sign this authorization.

_____ _____

Patient Name Date

_____

Signature (Patient, Parent/Guardian)

Acknowledgement

I have read and understand the above policies of Allergy & Asthma Center of Texas. I agree to the policies above and understand that I am responsible for payment for services I receive. This form must be signed to be seen at the Allergy & Asthma Center of Texas.

_____ _____

Patient Name Date

_____

Signature (Patient, Parent/Guardian)