NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

REGISTRATION FORM & POLICIES (Please Print Legibly)

Date: _____ Name: _____

How did you hear about us: _____ E-mail: _____

Primary Care Physician: _____ Contact #: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Marital Status: child S M W D

Date of Birth: _____ Age: _____ Ethnicity: _____Social Security #: _____

Pharmacy: _____ Pharmacy address: _____ Pharmacy #: _____

INSURANCE POLICY HOLDER (if different from above):

Name: _____ Relationship: _____

Address: _____

Employer: _____ Date of Birth: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PLEASE ALLOW US TO MAKE COPIES OF YOUR INSURANCE CARD AND TO TAKE A PICTURE OF YOU. WE KINDLY REQUEST THAT YOU NOTIFY US PROMPTLY OF ANY INSURANCE CHANGES. PLEASE INITIAL AFTER REVIEWING EACH SECTION.

_____ **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONDITIONS OF TREATMENT:** I (we) acknowledge that I (we) have been provided and have reviewed the Notice of Privacy Practices (dated June 1, 2018) and Conditions of Treatment. I (we) understand that as part of my healthcare, North Texas Allergy & Asthma Associates ("NTAAA") originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I (we) understand that this information is utilized to plan my (our) care and treatment, to bill for services provided to me (us), to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals and as required or permitted by law without my (our) consent. The Notice of Privacy Practices provides specific information and complete description of how my (our) personal health information may be used and disclosed. I (we) understand that NTAAA reserves the right to change the Notice of Privacy Practices and will notify me (us) when a revised Notice of Privacy Practices is available.

_____ **AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION:** I (we) authorize NTAAA to release my (our) medical information and/or individually identifiable health information to me (us) or my (our) duly authorized representative (as noted below), representatives of local, state, or federal agencies and insurance companies or other organizations or entities as may be required or permitted under federal or state law or as may be required for review or payment of claims. I (we) further authorize NTAAA to release such information to physicians, hospital, or healthcare providers needing such information to treat me (us) or to review my treatment. I (we) 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 (we) also understand that this authorization may be revoked by me by a written and dated notice, except to the extent that disclosure of information has been made prior or receipt of such revocation.

Below is a list of persons, whom we may inquire and/or be informed about your general medical information, conditions, or diagnosis.

Emergency Contact: _____ Relationship: _____ Cell Phone #: _____

Information allowed to be released to above (please check): ___ All health information, OR

___ Visit Notes ___ Billing Inquiries ___ Diagnostic Results ___ General Calls ___ Consultation Reports ___ Other: _____

Secondary Contact: _____ Relationship: _____ Cell Phone #: _____

Information allowed to be released to above (please check): ___ All health information, OR

___ Visit Notes ___ Billing Inquiries ___ Diagnostic Results ___ General Calls ___ Consultation Reports ___ Other: _____

_____ **AUTHORIZATION TO MAIL, CALL, TEXT OR E-MAIL:** I (we) hereby authorize NTAAA physicians and staff to leave a detailed message regarding lab results or other clinical information related to my (our) care. This authorization allows NTAAA to contact me (us) by telephone at any number associated with the account, including wireless telephone numbers, and emails so that NTAAA can service the account or collect any amounts owed. I (we) may also be contacted through text messages or emails and the method of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

_____ **INSURANCE AND PAYMENT ACKNOWLEDGEMENT:** Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and financial arrangements. Your clear understanding of our financial policies is important to our professional relationship. We participate and accept assignment for most insurance plans in the area. We submit claims to Medicare, Tricare, PPO, HMO, EPO, POS or any other insurance (excluding Medicaid as we do not participate in this program) on your behalf. **It is essential that you ensure we are a participating provider and provide us with your complete and accurate insurance information at the time your appointment is made.** It is important that all your insurance plan's requirements are met prior to providing services. This may include your payment of copays, deductibles, and any non-covered services at time of rendered service, and that pre-authorizations and required referrals are obtained prior to service. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company requires an authorization or referral, it is the patient's responsibility to obtain this for the initial visit and for continuation of care (but we will assist where possible). It is your responsibility to pay for all services provided that are not covered by your insurance. That includes amounts denied or not covered by your insurance plan. We are happy to provide any services you need, but if your insurance plan does not cover a specific service, you will be required to self-pay for these non-covered services. If we have not received your payment from your insurance plan by 45 days after the date of service or the insurance plan has denied in full or part, we will bill the balance to you. Please contact our billing office if you have any additional questions about our fees, financial policies, your insurance coverage, or financial responsibilities.

_____ **ASSIGNMENT OF BENEFITS:** I hereby assign all medical benefits to which I am entitled to NTAAA, and I authorize NTAAA to release any information required to process claims, unless rescinded by me in writing. I authorize payment of medical benefits to NTAAA for services performed.

_____ **PATIENT PAYMENTS:** Payments of copays, deductibles, and non-covered services are expected at the time of service. Patients without insurance are expected to make payment or other arrangements ideally prior to the service being performed. We accept cash, checks, credit cards and health savings accounts (HSA). Checks returned for non-sufficient funds will be charged $25.00. You will receive a monthly statement (payable upon receipt) showing you your balance after insurance has completed their processing and payment of the eligible benefits. I acknowledge that failure to pay an outstanding balance or contacting the office will result in interest and late fees added to my account, but we do offer 0% financing & monthly payment plans for all accounts if they are in good standing. If your balance becomes more than 90 days old, then interest of 12% and late fees of $25.00 will be assessed monthly on overdue balances. We understand that medical bills are often expensive and thus we want to work with you to make sure it is affordable but can only happen if we have open lines of communication. If I am unable to pay in full at this time, I will make payment arrangements with NTAAA. Account balances that have not been paid within 120 days or are not on an approved payment plan will be turned over to a licensed collection agency.

_____ **OTHER FEES:** Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education and training and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time. **Missed Appointments:** Please understand that when you reserve an appointment with one of our physicians, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. To assist all our patients with appropriate access to our physicians, we may charge a self-pay fee for repeated appointments that are cancelled with less than 24 hours' notice. **Medical Forms:** The completion of disability forms, attending physician statements and other supplemental insurance forms all require physician and staff time to complete. Accordingly, a $50.00 fee may be charged to complete these forms.

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for providing correct insurance information, and payment of any services not covered or approved by the insurance carrier.

Patient Name: _____Patient Signature: _____

IF A MINOR, PLEASE COMPLETE BELOW: Custodial Guardian (where the child lives) – Parent or legal guardian:

Relationship: _____ Name: _____ Signature: _____

Date of Birth: _____ Age: ____ Social Security #: _____ Cell Phone: _____

Secondary Guardian (who is legally authorized individual to bring in minor for treatment) – Must be at least 18 years of age

Relationship: _____ Name: _____ Signature: _____

Date of Birth: _____ Age: ____ Social Security #: _____ Cell Phone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT PORTAL AUTHORIZATION FORM & TELEMEDICINE CONSENT FORM

The Patient Portal is designed to improve physician and patient communication at North Texas Allergy & Asthma Associates (NTAAA). The patient portal is not designed to replace the face-to-face encounter. Once you are established as a patient and have provided us with your secure email you will be assigned a username and password. After your patient portal registration has been completed, you will be able to update your contact information, request appointments, see your diagnostic results, receive reminders through e-mail, review your medical summary, medication list, treatment history, office visits & even pay your outstanding balance. **There is no fee to use the portal.**

The following will **NOT** be accepted through the Patient Portal: (1) receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when you are seen for an office visit (2) requesting narcotics or controlled medications or (3) medication refills for medication not currently being prescribed by a NTAAA Provider.

Some important Patient Portal guidelines: Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency, you should call 911. If you have an urgent request, please contact the office via telephone.

- Avoid using a public computer to access the Patient Portal. After you are finished, be sure to logout and close your browser.
- The Patient Portal is provided as a courtesy service for our patients. All information on the portal is considered part of your medical record.
- We encourage you to use the portal at any time; however, messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office. If you have not heard from us within 3 business days, please call our office.
- We reserve the right to suspend access to the patient portal at any time and for any reason.
- If your message contains too many complex issues, we will ask you to come in for an appointment.
- Patient or legal guardian must be at least 18 years of age to be eligible to access the Patient Portal.

How the Patient Portal Security Works: A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks: This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect, but we will do our best to maintain electronic security. However, keeping messages secure depends on the secure message reaching the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to the message. Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address**. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Telemedicine: according to the Centers for Medicare & Medicaid Services, is "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance." There are multiple criteria for both patient and provider to fulfill in order for a consultation to be deemed an appropriate Telemedicine visit. We are unsure how individual insurance companies, including Medicare and commercial, will be covering the Telemedicine consultations. While we want to continue providing quality health care to all our patients, we also need to pay our bills and employees. Therefore, we are requesting North Texas Allergy & Asthma Associates (NTAAA) patients acknowledge the following:

- I understand that all federal and state laws protecting the privacy and confidentiality of medical information, apply to telemedicine.
- Video conferencing with your provider will be through the HIPAA compliant telemedicine service provider or telephone.
- I understand that video conferencing technology may be used and that the visit may not be the same as a direct health care provider visit due to the fact that I will not be in the same room as my health care provider.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand that my healthcare provider or I can discontinue the telemedicine consult/visit and future telemedicine visits at any time. I understand that withdrawal of my telemedicine consent will not affect my future care nor treatment.
- I understand that certain procedures such as a physical exam, allergy testing, etc. cannot be performed via telemedicine.
- I understand my health care provider may feel the telemedicine discussion may not be adequate and may request an actual visit to the office for more detailed consultation and examination. If that is so, I will only be charged for the in-office consultation.
- I understand that my insurance may not pay for this telemedicine service, even if my provider feels this is a treatment option I need.
- I understand that I will be required to pay the applicable co-pay before the visit occurs. NTAAA staff will do their best to verify that my insurance covers telemedicine visits. If this visit is deemed as not part of my insurance benefits, I understand that I am responsible for the cash-price fee of $50.00.

My Responsibilities for Telemedicine:

- I understand that I must be physically within Texas to be eligible for telemedicine and that my healthcare provider can send prescriptions for medications only to Texas pharmacies or addresses. My provider will not be sending narcotic medications through a telemedicine-based consultation.
- I will not record any telemedicine session without written consent from NTAAA and NTAAA will not record any session without my written consent
- I will inform my healthcare provider as soon as my session begins if there are any other surrounding people that are listening or watching the session. If there are surrounding people that will stay for the session, I am giving my consent for them to listen in on my medical care.
- I will notify my healthcare provider if there is any point in the consultation that my equipment fails, and I am unable to have clear audio.

Regarding payment for services rendered, I am requesting the option below (please initial):

_____ Option 1 - I want my insurance to be billed for this Telemedicine visit and will pay the applicable copay before the consultation. However, if my insurance company does not pay for the visit, then I am responsible for the office cash-price fee of **$50.00 for follow-up patients or $100.00 for new patients**. If my insurance does pay, NTAAA will refund any payments I made, less copays or deductibles.

_____ Option 2 - I will pay for the cash-price fee of **$50.00 for follow-up patients or $100.00 for new patients** and insurance will not be billed. I will not attempt nor request NTAAA to file any claims at a later time to any insurance carrier for coverage of services rendered to me for this telemedicine visit.

_____ Option 3 - I decline the option for the Telemedicine consultation.

Patient Acknowledgement and Agreement: I (we) acknowledge that I (we) have read and fully understand this form and the policies & guidelines regarding the Patient Portal and Telemedicine. I (we) understand the risks associated with online communications between my physician and me (us), and consent to the conditions outlined herein. In addition, I (we) agree to follow the instructions set forth herein, including the policies and guidelines set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I (we) understand and agree with the information that I (we) have been provided.

Email Address: _____ Date: _____

Patient Name: _____ If minor, Name of Legal Guardian _____

Patient Signature: _____ Signature of Legal Guardian: _____

NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Locations throughout Dallas – Specializing in personalized care since 1927
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E-mail: general@texasallergyonline.com
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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 disclosure is not meant to frighten or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to the procedures recommended to you.

I (we) am (are) of sound mental and physical condition, and I (we) am (are) able to give informed consent. I (we) acknowledge that I (we) am (are) fully aware of the care, treatment, and/or services that I (we) am (are) going to receive that is subject to of this form. I (we) voluntarily request North Texas Allergy & Asthma Associates ("NTAAA") staff physicians, and such associates, and other health care providers as they may deem necessary, 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 (we) understand that the following medical and/or diagnostic procedures may be necessary for me (us), and I (we) voluntarily consent and authorize these procedures as deemed necessary upon examination:

1) Skin testing (Percutaneous and Intradermal)
2) Patch tests
3) Immunizations
4) Spirometry & Niox
5) Blood or Imaging studies (CT, X-rays)
6) Oral challenges or desensitization's
7) Rhinopharyngolaryngoscopy (rhinoscopy)
8) Punch Biopsy

I (we) understand that my physician may discover other or different conditions, which may require additional or different procedures than those planned. I (we) 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 (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment. I (we) 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 (we) 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 (we) understand that the immunotherapy is to be administered under a physician's supervision. Furthermore, I (we) understand that it is required for me to wait in the waiting room **AT LEAST 30 MINUTES** after each allergy injection. If I (we) leave early, I (we) understand that it is against medical advice and will hold my treating physician and staff at NTAAA free of any liability.
- For patients that have anesthetics administered: I (we) understand that anesthesia involves the additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned procedure. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us). I (we) understand that certain complications may result from the use of any anesthetic, including respiratory problems, drug reactions, paralysis, brain damage or even death.

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

Date: _____

Patient Name: _____ If minor, Name of Legal Guardian _____

Patient Signature: _____ Signature of Legal Guardian: _____

NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Date: **(Please be sure to complete reverse)** **Name:**

Physicians
PCP:
Specialist MD:
Specialist MD:
Specialist MD:

	Current Medical Diagnosis
	Heart attack
	High blood pressure
	Diabetes
	Kidney disease
	Liver disease
	Stroke
	Cataracts
	Glaucoma
	Acid reflux disease
	Thyroid disease
	Auto-Immune disease

	Surgical History (include year)
	Eye surgery
	Sinus surgery
	Ear surgery
	Removal of tonsils
	Removal of adenoids
	Removal of appendix
	Removal of gall bladder
	Other

	General
	Fever
	Chills
	Weight Gain/Loss

	Ears, Nose, and Throat
	Frequent ear infections
	Ringing in the ear
	Ear surgery
	Ear tubes
	Hearing loss
	Dizzy spells
	Snoring
	Sleep apnea
	Hoarseness
	Frequent sore throats
	Trouble swallowing

	Cancer
	Type

	For Women Only
	Are you currently pregnant
	Planning pregnancy in the future

	Eyes
	Eye surgery
	Cataract
	Glaucoma
	Blurred vision
	Double vision
	Eye pain
	Infection of eyelashes or lids

	Gastrointestinal
	Loss of Appetite
	Nausea/Vomiting
	Abdominal Pain
	Diarrhea
	Constipation
	Vomiting blood
	Blood in stool
	Diverticulitis
	Jaundice
	Hepatitis
	Heartburn
	GERD
	Ulcer
	Hiatal hernia
	Inflammatory Bowel Disease
	Irritable Bowel Syndromes (IBS)

	Skin
	Hives
	Rash
	Eczema
	Skin cancer
	Psoriasis

	Heart
	High blood pressure
	Chest pain
	Heart murmur
	Heart palpitations
	Irregular pulse
	Heart attack
	Pacemaker

	Musculoskeletal
	Joint pain
	Joint stiffness
	Weakness of muscles/joints
	Muscle pain or cramps
	Rheumatoid arthritis
	Other arthritis syndromes
	Gout
	Sciatica
	Frequent neck pain
	Frequent back pain
	Osteoporosis

	Endocrine
	Thyroid disease
	Diabetes
	Frequent thirst
	Heat intolerance
	Cold intolerance
	Easily fatigued

	Lung & Chest
	COPD
	Pneumonia
	Pleurisy
	Chronic Bronchitis

	Neurological
	Migraine
	Headaches
	Frequent dizzy spells
	Lightheaded
	Seizure disorder
	Tremor/hand shaking
	Stroke
	Numbness or Tingling
	Weakness

	Hematologic
	Easily bruised or bleed
	Anemia
	Blood clots
	Blood transfusion
	Swollen glands

	Psychiatric
	Anxiety
	Memory loss
	Moodiness

Smoking History
Do you smoke?
If yes - what do you smoke:
How many years:
How many packs per day:
Exposed to 2nd hand smoke?:

Alcohol Use
Do you drink alcohol?
If yes - what kind:
How many times a day?

Illicit Drug Use
Do you take any illegal drugs?
If yes - what kind:
How did you use?

Medications

Please list all medications including supplements and over the counter drugs you are taking. Be sure to indicate strength and how many times a day. If you have a list of medications, please provide it to a medical assistant and you can skip this list.

Family History

	Mother	Father	Brother (s)	Sister (s)	Maternal Grandparents	Paternal Grandparents	Son (s)	Daughters (s)
Allergies								
Asthma								
Eczema								
Sinus Problems								
Hives								
Food Allergies								
Thyroid Disease								
COPD								
Immunodeficiency								
Heart disease/heart attack								
Stroke								
Auto-immune Disease								
Cancer (indicate type)								

Environmental History

Animal Exposure

Do you have any pets?

Number of cats:

- ☐ Sleep indoors
- ☐ Sleep outdoors

Number of dogs:

- ☐ Sleep indoors
- ☐ Sleep outdoors

Number of birds:

Number of gerbils/guinea pigs:

Number of horses:

Other animals:

Are you exposed to any animals at work?

What kind?

Other:

Type of home:

Years in current home:

- ☐ House
- ☐ Apartment
- ☐ Mobile home
- ☐ Farm

Type of pillows:

Do you have pillow covers?

- ☐ Feather/Down
- ☐ Polyester
- ☐ Foam

Mattress:

Regarding your mattress:

How old?

Mattress covers?

Type of plants:

- ☐ Live
- ☐ Silk
- ☐ Don't have

Type of flooring:

- ☐ Carpeted
- ☐ Hardwood
- ☐ Tile
- ☐ Vinyl

Type of A/C:

- ☐ Central
- ☐ Window
- ☐ Cooler

Type of heating:

- ☐ Oil/gas
- ☐ Electric
- ☐ Coal
- ☐ Gas fireplace
- ☐ Wood fireplace
- ☐ Wood stove

Any of the following in your home?

- ☐ Ceiling fans
- ☐ Humidifier
- ☐ Air filter
- ☐ Stuffed animals
- ☐ Bookcases

Other

Are you sensitive to perfumes?

What kind?