**Allergy & Asthma Consultants, L.L.P.**
720 W. 34th Street • Suite 200 • Austin, Texas 78705
Office (512) 454-5821 • Fax (512) 459-9137

MRN_____
DR_____
ENTERED_____
VERIFIED_____

# 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 ____/____/____
MM/DD/YYYY

Social Security #

**Primary Insurance Company**

Name

**Secondary Insurance Company**

Name

**Primary Care Physician**

Name City State

## Referred by

Physician _____ Friend ☐ Newspaper Ad ☐ Yellow Pages ☐ Insurance ☐
Name Internet ☐ Other _____



**PATIENT LABEL**

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MRN_____
DR_____
ENTERED_____
VERIFIED_____

# PATIENT INFORMATION

**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** ☐, **Dr. Alexander Alvarez** ☐ 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



**PATIENT LABEL**

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**Date:** _____ **Print Name:** _____

**Referring Physician:** _____

**Reason for Visit:** _____

_____

_____

_____

_____

## Check Symptoms You Have or Have Had:

**Nasal Symptoms**
- ❑ Frequent sneezing
- ❑ Runny nose
- ❑ Nasal congestion
- ❑ Nose bleeds
- ❑ Loss of smell
- ❑ Nasal polyps

**Sinus Symptoms**
- ❑ Frequent infections
- ❑ Pressure in cheeks
- ❑ Pressure around eyes
- ❑ Post nasal drip
- ❑ Prior sinus surgery

**Eye Symptoms**
- ❑ Itching
- ❑ Burning
- ❑ Redness
- ❑ Swelling of eyelids
- ❑ Matting

**Ear Symptoms**
- ❑ Pain
- ❑ Itching
- ❑ Plugging
- ❑ Loss of hearing
- ❑ Ringing

**Are Your Symptoms Worse:**
- ❑ At home
- ❑ At work
- ❑ Out doors
- ❑ Around smoke
- ❑ Around fumes

**Respiratory Symptoms**
- ❑ Asthma
- ❑ Wheezing
- ❑ Coughing
- ❑ Productive cough
- ❑ Dry cough
- ❑ Night-time cough
- ❑ Exercise-induced wheezing
- ❑ Exercise-induced cough
- ❑ Chest tightness
- ❑ Anything relieve the chest tightness? _____
- ❑ Aspirin worsen asthma

**Abdominal Symptoms**
- ❑ Weight loss
- ❑ Heartburn or reflux
- ❑ Frequent diarrhea
- ❑ Known food allergies

List:_____

_____

_____

_____

**Skin Complaints**
- ❑ Childhood eczema
- ❑ Hives
- ❑ Contact rash
- ❑ Itching

- ❑ In the winter
- ❑ In the spring
- ❑ In the summer
- ❑ In the fall

**Headache Pains**
- ❑ Sinus
- ❑ Migraine
- ❑ Tension
- ❑ Associated with menses

**Location**
- ❑ Frontal
- ❑ Temporal Area

Other site: _____

**Frequency**
- ❑ Daily
- ❑ Occasionally
- ❑ Seldom

**Other Serious Infections**
- ❑ Ear infections
- ❑ Pneumonia
- ❑ Skin
- ❑ Meningitis

**Stinging Insect Reactions**
- ❑ Large local reactions
- ❑ Anaphylaxis

Type of insect: _____

- ❑ With any activity

List:

_____

_____

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**Environmental and Social History:**

What is your occupation?_____

What type of home do you live in? Single-family home: o Apartment: o Farm or ranch: o

Do you have carpets in the bedrooms? Yes o No o

Do you have feather pillows? Yes o No o

Do you exercise regularly? Daily: o Occasionally: o

Type of exercise: _____

**Exposure History:**

Any unusual work exposures:_____

Any unusual hobbies or sports: _____

Do you have any pets? Dogs _____ Cats _____ Other _____

Do the pets live indoors? Yes o No o

Do the pets sleep in the bedroom? Yes o No o

Does exposure to any pets increase your symptoms? Yes o No o

**Medical History:**

Primary Care Physician: _____

Have you ever had previous allergy testing? Yes o No o

If so, when? _____

Have you seen an ear, nose, and throat (ENT) physician? Yes o No o

Have you had an adenoidectomy? Yes o No o

Have you had a tonsillectomy? Yes o No o

Any history of injury to your face or nose? Yes o No o

Have you had any other surgeries? Yes o No o

Please list: _____

Have you had a recent chest x-ray? Yes o No o

Date: _____

Have you had a recent sinus CAT scan or x-ray? Yes o No o

Date: _____

Do you smoke? Yes o No o

If so, how many packs: _____

Have you ever smoked? Yes o No o

If so, how long did you smoke: _____

**Medication History:**

Present medications (please list medicine and dose if possible):

_____

_____

Any known medication allergies? Yes o No o

If so, please list with reaction: _____

**Family History:**

| | Grand-Parents | Father | Mother | Brother | Sister | Children |
|---|---|---|---|---|---|---|
| Asthma | o | o | o | o | o | o |
| Allergies | o | o | o | o | o | o |
| Eczema | o | o | o | o | o | o |
| Insect Allergies | o | o | o | o | o | o |
| Food Allergies | o | o | o | o | o | o |
| Hives | o | o | o | o | o | o |
| Chronic Obstructive Pulmonary Disease (COPD) | o | o | o | o | o | o |

# Allergy & Asthma Consultants, L.L.P.

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**Personal Medication Record for:** _____

Use this form to record all medications you are taking. Be sure to update the list when you start taking a new medicine.

## PRESCRIPTION MEDICATIONS

| Name | Why do you take it? (Your medical condition) | Dosage Medication Strength Number of times you take it daily | How do you take? Time of day. With or without food? | Prescribing Doctor |
|---|---|---|---|---|
| **Example**: Benadryl | Allergies | 25 mg once daily | At bedtime | Dr. Smith |
| | | | | |
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## OVER THE COUNTER MEDICINES (Including vitamins and herbal products)

| Name | Why do you take it? (Your medical condition) | Dosage Medication Strength Number of times you take it daily | How do you take? Time of day. With or without food? | Prescribing Doctor |
|---|---|---|---|---|
| Example: Tylenol | Arthritis Pain | 1000 mg (2 tablets) every 6 hours | As needed | None |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |

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720 W 34TH ST · STE 200 · AUSTIN, TX 78705
PHONE (512) 454-5821 · FAX (512) 459-9137
WWW.AUSTINALLERGY.COM

## ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand I have the right to review Allergy & Asthma Consultants, L.L.P. **Notice of Privacy Practices** prior to signing this document. Allergy & Asthma Consultants, L.L.P. Notice of Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of Allergy & Asthma Consultants, L.L.P.. This Notice of Privacy Practices also describes my rights and Allergy & Asthma Consultants, L.L.P. duties with respect to my protected health information.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my Physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe such information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the health care operations of Allergy & Asthma Consultants, L.L.P. Allergy & Asthma Consultants, L.L.P. is not required to agree to any restriction that I may request. If, however, Allergy & Asthma Consultants, L.L.P. agrees to any restriction request by me, such restriction shall be binding on Allergy & Asthma Consultants, L.L.P. and **Dr. T.S. Painter, Jr.**☐, **Dr. Edward J. Peters**☐ , **Dr. Maria G. Gutierrez**☐ , **Dr. Paul G. Vigo**☐ , **Dr. Alexander Alvarez**☐ and any assisting providers. I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Allergy & Asthma Consultants, L.L.P. and **Dr. T.S. Painter, Jr.**☐ , **Dr. Edward J. Peters** ☐ , **Dr. Maria G. Gutierrez** ☐ , **Dr. Paul G. Vigo**☐ , **Dr. Alexander Alvarez**☐ and any assisting providers have taken action in reliance on this consent.

Please also note that as provided in Allergy & Asthma Consultants, L.L.P. Notice of Privacy Practices, Allergy & Asthma Consultants, L.L.P. reserves the right to change the privacy practices that are described in such notice. I may obtain a revised Notice of Privacy Practices by accessing Allergy & Asthma Consultants, L.L.P. website (www.austinallergy.com) calling the office at (512)454-5821 and requesting a revised copy be mailed to me, or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____
Name of Patient or Patient's Authorized Representative

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ Individual refused to sign
☐ Communication barrier prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other:_____

_____

_____ _____
HIPAA Officer Signature Date



Patient Label

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## PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE AND CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

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:

_____

_____

Your Primary Message Phone No.: (_____) _____

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

| Family Member/Personal Representative | Relationship to Patient/ Phone No. |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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.

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____

*Please leave patient's name and date of birth when Leaving a voicemail.*

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

_____ _____
Patient Name Date

_____
Patient Signature



Patient Label