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 _____/_____/_____ Social Security # _____
MM/DD/YYYY

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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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