TEXAS REGIONAL ASTHMA AND ALLERGY CENTER, L.L.P.

Board Certified specialists in allergy, asthma, immunology, and respiratory disorders

RICHARD A. MAYSE, M.D., RENE ALBERT LEON, M.D., ALI SHAKOURI, M.D., SHARON SETH, M.D.

900 East Southlake Blvd. Suite 300 Southlake Texas 76092

(817) 421-0770 (Main) (817) 421-4759 or (817) 424-8431 (Fax)

WEBSITE: www.traac.org

DR. SETH - NEW PATIENT EVALUATION

Please fill this in as well as you can. This will make your evaluation more efficient.

Print Name: _____ DOB: _____ Today's Date: _____

Reason to be here today: _____

Referring physician's name & city: _____

What is your current job (if in school, what grade):_____

Smoker? Yes_____ No_____

I have lived in the DFW area for _____ years. I moved here from:_____

Indoor Pets: _____

Medications for allergies/asthma:_____

_____

_____

_____

Family members with allergies/asthma:_____

_____

Previous allergy testing? _____ NO _____ YES, when?:_____

Previous allergy shots? _____ NO _____YES, where?:_____

Other medical problems I have:

___High blood pressure ___Acid Reflux ___Diabetes ___Heart disease

___Thyroid disease ___Arthritis ___Cancer ___Elevated cholesterol

DOCTOR NOTES:

I agree to pay for all services rendered whether or not paid by my insurance. If applicable, I agree to pay my co-payment and/or deductible & out-of-pocket at the time of service. I understand that I will be held fully responsible for any services deemed as non-covered or denied by my health insurance company.

Patient Information Form

TEXAS REGIONAL ASTHMA & ALLERGY CTR

Appt Date/Time: Appt Provider: Chart #

Appt Comments:

Patient Information

First Name Middle Initial Last Name

Address Address Line 2 City State Zip Code

Email Preferred Language SSN Date of Birth

Driver's License State Primary Phone Phone Type Secondary Phone Phone Type

Gender ___ Male ___ Female

Marital Status _____

Ethnicity ___ Hispanic/Latino ___ Not Hispanic/Latino ___ Declined

Race ___ White ___ Black or African American ___ American Indian or Alaskan Native ___ Asian ___ Native Hawaiian or Other Pacific Islander ___ Hispanic ___ Declined

Employer Name Employer Phone

Emergency Contact Name Emergency Contact Phone Relationship to Patient

Referring Physician Primary Care Physician

Insurance Information

Primary Insurance Member # Group #

Primary Insured Name SSN Relationship Date of Birth Gender ___ Male ___ Female

Secondary Insurance Member # Group #

Primary Insured Name SSN Relationship Date of Birth Gender ___ Male ___ Female

Financial Responsibility Information

Responsible Party Name SSN Relationship to Patient Primary Phone

Address Address Line 2 City State Zip Code

Preferred Pharmacy

Pharmacy Name Pharmacy Phone Pharmacy Address

Patient/Guardian Signature

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I understand that I may make payment in the form of cash, check, or credit card (Mastercard, VISA, or Discover). I understand that my failure to make payment will result in future collection proceedings ($15 service fee will be applied). I understand that there is a $35.00 service fee on all returned checks.

I understand that I am welcome to contact the business office of Texas Regional Asthma & Allergy Center (TRAAC) to discuss any questions relating to my account.

I understand that TRAAC requires a 1 business day notification of cancellation for appointments & procedures. TRAACs policy is to charge $25.00 for no shows or late cancellations (subject to extenuating circumstances).

I certify I am 18 years of age/or the legal guardian of the patient. If I am the legal guardian/guarantor, I understand that I am financially responsible for the patient.

I assign insurance benefits and authorize treatments to be rendered by TRAAC.

I agree to release all such medical information that may be necessary to insure payment of my insurance claim(s).

I agree to notify TRAAC of any changes in my insurance status prior to treatment or I will be fully responsible for services rendered.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____

Patients Name:_____

Signature of Patient/Legal Guardian:_____

TRAAC Facsimile Authorization Form

I, the undersigned, authorize TRAAC to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below.

I may revoke this authorization by giving TRAAC five (5) days written notice. This revocation may be facsimile transmission: however a **written copy of the revocation must be mailed to TRAAC as well.**

Patient Name:_____

Signature of Patient or Parent of Minor: _____

Contact Information

Where can you be reached during business hours: ☐ Home ☐ Work ☐ Cell

May we contact you at home? ☐ YES ☐ NO
May we contact you at your place of business? ☐ YES ☐ NO

Leave Message:

Voicemail / Answering Machine ☐ YES ☐ NO
Family Member ☐ YES ☐ NO

May we contact you via email? ☐ YES ☐ NO Email address:_____
May we contact you via text message? (for appointment reminders only) ☐ YES ☐ NO

I hereby give permission to TRAAC to disclose any information related to my medical conditions to / with the following members (relatives, or close personal friends):

Name:_____ Relationship:_____
Name:_____ Relationship:_____

I do/do not wish to give permission for any family members, relatives, or close personal friends to have access to any information regarding my medical conditions:

☐ I do NOT wish to give permission ☐ I DO give permission to the above name(s)

Signature of Patient or Parent of Minor:_____ **Date:**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of TEXAS REGIONAL ASTHMA & ALLERGY CENTER's "Notice of Privacy Practices". This notice describes how **TEXAS REGIONAL ASTHMA AND ALLERGY CENTER** may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient or Personal Representative) (Date)

_____

(Relationship to patient)