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

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

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

RENE ALBERT LEON, M.D. ALI SHAKOURI, M.D. ERNESTO RUIZ-HUIDOBRO, M.D. ALAYNA POWERS, RN, FNP-C ALISHA DIAZ, PA-C

900 East Southlake Blvd. Suite 300 Southlake Texas 76092 (817) 421-0770 (817) 421-4759 (Fax)

4312 Heritage Trace Pkwy. Ste 708 Fort Worth, TX 76244 (817) 421-0770 (817) 562-5008 (fax)

WEBSITE: www.traac.org

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.

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. 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. Our 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 HIPPA (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   Cell Phone ☐ YES ☐ NO
Family Member ☐ YES ☐ NO   Co-Worker ☐ YES ☐ NO

May we contact you via email? ☐ YES ☐ NO Email Address: ____________________

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:** __________

TEXAS REGIONAL ASTHMA & ALLERGY CENTER

900 East Southlake Blvd., Suite 300, Southlake, Texas 76092 (817) 421-0770

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and Disclosed and how you can get access to this information. Please review it Carefully.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with TEXAS REGIONAL ASTHMA & ALLERGY CENTER. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

TEXAS REGIONAL ASTHMA & ALLERGY CENTER is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice please contact our Privacy Manager at 817-421-0770 ext 143.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices- We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure- This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative- This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information – This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

You have the right to request a restriction of your protected health information-This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request. For a restriction.

You may have the right to have us amend your protected health information – This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability – This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment- We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For Payment –Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations- We may use or disclose, as-needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law- We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health- We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases- We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight- We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victims of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration- We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation- We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity- Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security- When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

For Worker's Compensation- Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

When an Inmate- We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures- Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Notice of Privacy Practices
TEXAS REGIONAL ASTHMA & ALLERGY CENTER

3/2022

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

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

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WEBSITE: www.traac.org

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ________________________________ acknowledge that TRAAC has provided a copy of Texas Regional Asthma & Allergy Center's "Notice of Privacy Practices". This notice describes how TEXAS REGIONAL ASTHMA & 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/Legal Guardian) (Date)

____

(Relationship to Patient)

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DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Rene A. Leon, M.D. and Ali Shakouri, M.D. are owner investors of Methodist Southlake Hospital in Southlake, TX.
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Methodist Southlake Hospital in Southlake, TX.
3. You will **not** be treated differently by your physician if you choose to obtain health care services at a facility other than Methodist Southlake Hospital in Southlake, TX.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Methodist Southlake Hospital in Southlake, TX. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand the foregoing notice and understand that you physician has an ownership interest in Methodist Southlake Hospital in Southlake, TX.

______________________________	______________________________
Signature of Patient	Signature of Parent or Guardian (if applicable)
______________________________	______________________________
Type or Print Name of Patient	Type or Print Name of Parent or Guardian (if applicable)

Date: ______________________________