

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Declined			
Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
Secondary Insurance	Member #	Group #			
Primary Insured Name	SSN	Relationship	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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			
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Patient/Guardian Signature

Date:

# Texas Regional Asthma and Allergy Center, L.L.P.

*Specialists in allergy, asthma, immunology, and respiratory disorders*

## New Patient Evaluation

Name:

Date of Birth:

Today's Date:

*The following responses will help us to better evaluate you:*

1. Reason you are here today:
2. Referring physician's name and city:
3. I have lived in the DFW area for \_\_\_\_\_ years. I moved here from:
4. What is your most bothersome symptom?
5. In what season(s) are your symptoms the worst?
6. Have you previously had allergy testing?      When?
7. Previously had allergy shots or allergy drops?      When?
8. Have you ever used an albuterol inhaler or other inhaler?
9. Have you ever taken medication for heartburn or acid reflux?
10. How many courses of antibiotics have you taken in the past 365 days?
11. Have you ever been hospitalized?      Most recent month/year?
12. Have you ever been to the ER or urgent care?      Most recent month/year?
13. What surgeries have you had?
14. Approximately how many days of work/school did you miss in the past 365 days?      Why?
15. Have you ever been stung by a bee, wasp, hornet, or ant?      What happened?
16. Have you ever had eczema or atopic dermatitis?
17. Which foods do you avoid and why?
  
18. Which medications or products do you avoid and why?
  
  
  
  
  
  
  
  
  
  
19. Have you ever had anaphylaxis or a severe allergic reaction?

Next -->



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

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*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. ZACHARY W. MARSHALL, M.D.*

*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](http://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 (\$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.

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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

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

### 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**

**9/2018**



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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 "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 or Personal Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to Patient)