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. SHARON SETH, M.D. ZACHARY W. MARSHALL, M.D. ALAYNA POWERS, R.N., FNP-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

Dr Seth- New Patient Evaluation

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

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

Reason for visit: _____

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

DOCTORS NOTES:

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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.

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:** _____