# Southwest Asthma & Allergy Associates

(Please Print)

| Today's Date: | Primary Care Physician: | Referring Physician: |
|---|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. |
|---|---|---|---|---|
| Street address: | City: | State: | ZIP Code: | |
| Home Phone no: ( ) | Cell Phone no.: ( ) | Email: | | |
| Birth date: | Age: | Sex: ☐ M ☐ F | Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐ | Social Security no.: |
| Employer: | Employer phone no.: ( ) | Ethnicity: | | |
| Chose clinic because/referred to clinic by (Please check one box): | ☐ Dr. | ☐ Insurance plan | ☐ Hospital | |
| ☐ Family | ☐ Friend | ☐ Close to home/work | ☐ Yellow Pages | ☐ Other |
| Other family members seen here: | | | | |
| If the above named patient was a minor, may we ask the name of each parent? | Mother: | Father: | | |

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist. Statements and bills will be addressed to responsible party.)

| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|
| S.S. no.: | Driver's License no.: | Issuing State: | |
| Subscriber name: | Birth date of Insurance Subscriber: | Sex: ☐ M ☐ F | |
| Patient's relationship to insured: | ☐ Self | ☐ Spouse | ☐ Child ☐ Other |
| Name of primary insurance: | Subscriber no.: | Group name: | Group no.: |
| Employer: | Employer address: | Employer phone no.: ( ) | |
| Name of Secondary Insurance (if applicable): | Subscriber name: | Birth date: | Subscriber no.: |
| Patient relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child ☐ Other |

## IN CASE OF EMERGENCY

| Emergency contact: | Relationship to patient: | Cell phone no.: ( ) | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|---|

## ADDITIONAL INFORMATION

| Pharmacy Name: | Pharmacy phone no.: ( ) | Pharmacy fax no.: ( ) |
|---|---|---|

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PHYSICIANS CERTIFIED BY THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

LEWIS A. BROWN, MD
SALVADOR FIGUEROA, MD
LEONARD HOFFMAN, MD
R. MATTHEW BLOEBAUM, MD
MONIQUE ALLMAN, PA-C
L. REED SHIRLEY, MD
YONGXIN CHEN, MD
KENNETH T. KRAY, MD
M. L. CHOU, MD
GLENN B. KLINE, MD
JAMES B. COOPER, MD
JUAN C. ZAMBRANO, MD
JEAN I. ENCARNACION, PA-C
JOHN KELLEY, M.D.

"Caring for Children and Adults with Asthma and Allergies"

## SWAAA FINANCIAL POLICY



Southwest Asthma & Allergy Associates believes that communicating our financial policy is good healthcare practice. **CHARGES INCURRED FOR SERVICES RENDERED ARE THE PATIENT'S RESPONSIBILITY REGARDLESS OF INSURANCE COVERAGE. YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, NOT YOUR INSURANCE COMPANY AND US.** We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

**YOU ARE RESPONSIBLE FOR ALL COPAYS, COINSURANCES, DEDUCTIBLES AND NON-COVERED SERVICES.** We are obliged to collect your copay at the time of service per your insurance company. Statements are sent out monthly and published to our patient portal. We require the balances due be paid when you receive your statement.
Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances, they are applied to the current date of service. There is a $25.00 charge for a check that does not clear your bank. Payment will then need to be made by cash, money order or credit card for the balance due.

When you receive healthcare services from us and we bill your insurance, it is the same as though we are extending credit to you. You receive the service and we await payment from you and / or your insurance company. Due to the high cost of rendering care and the lowering reimbursements by many insurers, including Medicare & Medicaid, we simply cannot afford to carry large balances. Further action will take place if balances are not paid within 90 days. Payment arrangements can be made with our account specialist representatives by calling 713-596-8500.

Form Requests:
Completing disability forms, FMLA forms and other requested supplemental insurance forms requires time away from patient care and day to day business operations. Prepayment of $25.00 is required. Please understand that in order to complete forms your medical record must be reviewed, forms completed and signed by the physician and scanned into your medical record. Some of these forms can be quite complicated and tedious to complete. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow five (5) business days for this process.

I have had the opportunity to read/receive a copy of the Financial and Privacy Policies of Southwest Asthma & Allergy Associates and hereby authorize any licensed physician, practitioner, hospital, clinic or other medical facility or it's representatives to release any and all information with respect to any illness or injury, medical history, consultation, prescription(s) or treatment and copies of medical records to: The physicians of Southwest Asthma & Allergy Associates. I also authorize Southwest Asthma & Allergy Associates, it's physician's and providers to release medical records to the insurance company responsible for my health coverage should it become necessary for payment of services provided.

_____ _____

**Patient / Guardian-Responsible Party** **Date**

I hereby assign benefits and authorize payment to go directly to Southwest Asthma & Allergy Associates for any medical services provided but not to exceed the reasonable and customary charges for these services.

**THIS OFFICE IS NOT RESPONSIBLE FOR INCORRECT BENEFIT INFORMATION GIVEN TO US BY YOUR HEALTH CARE INSURANCE CARRIER OR FOR CHANGES IN COVERAGE. A DESCRIPTION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE AND CANNOT BE RELIED UPON AS SUCH. IN THE EVENT OF NON-PAYMENT BY YOUR INSURANCE COMPANY THE CHARGES ON YOUR ACCOUNT WILL BE YOUR RESPONSIBILITY.**

I understand that I am financially responsible to the physician for all charges not covered by this agreement. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

**KNOWING YOUR INSURANCE BENFITS ARE THE RESPONSIBILITY OF THE INSURED AND DEPENDENTS. WE ARE ONLY PROVIDING INFORMATION GIVEN TO US BY YOUR INSURANCE COMPANY. THIS INFORMATION MAY NOT BE CORRECT AND SHOULD NOT BE RELIED UPON. PLEASE CONTACT YOUR INSURANCE COMPANY TO INSURE COVERAGE AND BENEFITS.**

We accept cash, debit card, check, (except starter checks and not from new patients), Master Card, Visa and American Express.

_____ _____

**Patient / Guardian-Responsible Party** **Date**

**Print Patient Name**_____**Account #**_____

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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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer-Dr. Juan Zambrano.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

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This notice is effective as of April 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from this office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Southwest Asthma & Allergy Associates
Juan Zambrano, M.D.
9494 SW Freeway, #600
Houston, TX 77074
(713) 596-8500

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

Southwest Asthma & Allergy Associates

# *Medical Information Release Form*

## *(HIPAA Release Form)*

**Name:** _____ **Date of Birth:** ____/____/____

## ***Release of Information***

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

## ***Messages***

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____