Allergy & Asthma Care of Wylie

Patient Information:

Patient Name:_____ Date of Birth:_____

Male__ Female__

Primary Phone:_____ Alternate Phone:_____

Email:_____

Preferred Method of Communication: Call___ Text__ Email__

Patient Address:

_____

_____

_____

Primary Insurance Name:

Plan Name and Type:_____

Insurance ID:_____ Group Number:_____

Secondary Insurance Name: ☐ **Check if no secondary insurance**

Plan Name and Type:_____

Insurance ID:_____ Group Number:_____

Policyholder's/Guarantor Insurance Information:

Relationship of Patient to Policyholder: Self__ Spouse__ Child__ Other__

Guarantor Name:_____ Date of Birth:_____

Male__ Female__

Primary Phone:_____

Address: ☐ **Same as patient**

_____

_____

Pharmacy you would like us to send any prescriptions:

Pharmacy Name, address, and phone:

_____

_____

_____

How did you hear about us? Check one or all that apply.

___Google ___ Facebook ___ Instagram ____ Current Patient

___Magazine Ad ___ Billboard ____ Healthcare Provider Referral (Please list below)

___ Other (please specify)

With your authorization, to coordinate your care, if you are self-referred or referred from a physician/provider who is not your Primary Care Provider (PCP), Dr. Angela will fax the clinic note regarding your visit to your PCP. Please provide us with your PCP information:

Primary Care Provider name, address, and phone:

_____

_____

_____

Next of Kin / Emergency Contact for Patient:

Name:_____

Relationship to Patient: Mother__ Father__ Child__ Spouse__ Other(Please specify):_____

Primary Phone:_____

Address: ☐ **Same as patient**

_____

_____

To improve our efficiency and your experience in our clinic, please list all medications that you are currently taking so that we can enter this information into your record before your appointment.

In a few words, what is the main concern you would like Dr. Angela to address?

Thank you for allowing us the opportunity to serve your allergy and asthma needs!

Ht: _____ ft. _____in. Wt:_____ lbs.
BP:_____/_____ Temp:_____F HR_____ O2_____%

1. Do you or any others in the home smoke cigarettes? Circle one: Yes No

2. Pets in home? Circle one: Yes No If yes, what type?_____

3. If student, what grade level? _____

4. If employed, occupation/employer? _____

5. Is there a family history of any of the below conditions? Please circle all that apply.
☐ Unsure of family history

Asthma:	Father	Mother	Sibling	None
Nasal allergies:	Father	Mother	Sibling	None
Eczema:	Father	Mother	Sibling	None

6. Has the patient had any of the following 3 or more days per week for the last 3 weeks? Circle any that apply.

Fever/Chills Recent change in weight Headache Sinus or ear pain

Difficulty breathing Wheezing Cough Heartburn Vomiting

Diarrhea Joint pain or swelling Fainting Easy bleeding

Dry eyes Vision changes Tender lymph nodes

7. Has the patient had any previous surgeries? Please circle. Yes No
If so, please list type and year _____

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8. Please list any chronic medical conditions or any medical conditions that you are currently being treated for._____
_____

9. Please list any medications that you are currently taking _____
_____

10. Is the patient allergic to any medications? Circle one. Yes No
If so, please list medication and the reaction. _____

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11. Is the patient allergic to latex? Yes No

Allergy & Asthma Care of Wylie

Patient Name: _____ Date of Birth: _____

HEALTHCARE INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

My signature on this form indicates I have received a copy of the "Notice of Privacy Practices." from ALLERGY AND ASTHMA CARE OF WYLIE and I understand how my healthcare information will be used and/or disclosed.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO ALLERGY & ASTHMA CARE OF WYLIE

I hereby authorize the release or disclosure of all medical records including any specially protected records such as those relating to psychological or psychiatric impairment, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

RELEASE OF INFORMATION TO ALLERGY & ASTHMA CARE OF WYLIE -

So that Dr. Fadahunsi has all the information she needs to provide medical care,

□ I authorize the release of my medical records to Allergy and Asthma Care of Wylie FROM ALL MEDICAL SOURCES.

OR

□ I authorize the release of my medical records to Allergy and Asthma Care of Wylie FROM ONLY THE FOLLOWING PROVIDER(S),

_____

RELEASE OF INFORMATION FROM ALLERGY & ASTHMA CARE OF WYLIE -

So that other Providers have all the information needed from my care at Allergy and Asthma Care of Wylie,

□ I authorize Allergy and Asthma Care of Wylie to release my medical records TO ALL MEDICAL SOURCES.

OR

□ I authorize Allergy and Asthma Care of Wylie to release my medical records TO ONLY THE FOLLOWING PROVIDER(S)

_____

The purpose of the above release of medical records is for medical care unless otherwise specified here:_____

If you **DO NOT WANT** certain portions of your medical records released, please check the box indicating the information you do not want released or specify:

□ Substance Abuse □ Psychological or psychiatric treatment □ HIV/AIDS/STD □OTHER _____



COMMUNICATIONS REGARDING YOUR HEALTHCARE INFORMATION

Please indicate with whom we may disclose your healthcare information. Check all that apply.

□ I authorize Allergy and Asthma Care of Wylie to leave phone messages regarding pending appointments on my phone.

□ I authorize Allergy and Asthma Care of Wylie to leave phone messages regarding test results on my phone.

□ I authorize Allergy and Asthma Care of Wylie to communicate information regarding my healthcare with the individuals listed below:

Name _____ Relationship _____

Name _____Relationship _____

□ Allergy and Asthma Care of Wylie **may not** communicate my healthcare information with anyone other than me.

I understand that I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

This authorization will expire one year from date signed unless otherwise specified here:_____

Printed Patient Name_____

Signature of Patient(or Authorized Representative)_____

Date:_____ Relationship to Patient: □Self □Mother □Father □ Spouse □ Other:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About This Notice
We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI, this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?
Protected Health Information (PHI) is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI
We may use and disclose your PHI in the following circumstances:
For Treatment. We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.
For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.
For Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.
Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.
As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.
To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.
Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.
Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

Right to Inspect and Copy. You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in one or more designated record sets electronically (for example an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured PHI.

Right to Request Amendments. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request.

In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

Newsletters and Other Communications. We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

_____. Printed Name

_____ Signature

_____ Date

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing ***Allergy and Asthma Care of Wylie*** as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.

- We are pleased to assist you by billing for our contracted insurers. In order to do this, we require that the you please provide us with the most correct and updated information about the insurance. The patient will be responsible for any charges incurred if the information provided is not correct or updated. It is the patient's responsibility to confirm whether we are in network with their insurance and the patient bears responsibility for payment.

- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service. For your convenience, we accept cash, check, and most major credit cards at our office.

- Patients may incur, and are responsible for the payment of additional charges at the discretion of Allergy and Asthma Care of Wylie. These charges may include (but are not limited to):

    - Charge for returned checks.
    - Charge for missed appointments without 24 hours advance notice
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
    - Charge for the copying and distribution of patient medical records.
    - Charge for extensive forms completion.
    - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize Allergy and Asthma Care of Wylie to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies and third party payers.

- By my signature below, I hereby authorize assignment of financial benefits directly to Allergy and Asthma Care of Wylie and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____

Printed Name of Patient (or parent/guardian if patient <18 years)

_____

Signature of Patient (or parent/guardian if patient <18 years)

_____

Date

Allergy & Asthma Care of Wylie

CANCELLATION AND MISSED APPOINTMENT POLICY

**Please note the following applies to appointments with the Doctor only and does not pertain to visits for injections.*

Cancellation Policy for Office Visits:

At Allergy and Asthma Care of Wylie your health is very important to us, which is why every time we book a visit for you, we book time in our doctor's schedule to serve your needs. We strive to be on time for your appointments and ask that you give us the same courtesy.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

We ask you, our patient, to please give us a minimum of **two business day** advanced notice for cancellations or to change your appointment.

Please note, because our office is closed Fridays, all Monday appointments will need to be changed by Wednesday at 5PM.
Office appointments which are cancelled or changed with less than two business day notice will be charged $25.00.

The cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Please note that such fees will NOT be covered by your insurance.

Numerous NO SHOW Policy:

Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW. Patients who have two (2) or more NO SHOWs in a 12 month period, will be required to prepay for any future appointments and may be limited to booking appointments in the immediately following 24-48 hour window.

Please sign that you have read, understand and agree to this cancellation/missed appointment policy.

Patient Name:_____

Parent/Guardian name (if patient is a minor): _____

Patient or Parent/Guardian Signature: _____ Date: _____

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972-954-9826 allergywylie.com