THE ALLERGY CLINIC
NO ONE NOSE ALLERGIES LIKE WE DO™

Fannin/Texas Medical Center
Museum District/Park Plaza - Pasadena - Pearland

PATIENT REGISTRATION FORM

DATE: _____

PATIENT NAME: _____ (Last), _____ (First), _____ (Middle) DATE OF BIRTH: _____ (mm/dd/yyyy)

SEX: ☐ FEMALE, ☐ MALE SS#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ DAYTIME PHONE: _____ CELL PHONE: _____

ARE YOU EMPLOYED? ☐ YES, ☐ NO EMPLOYER: _____

HOW WERE YOU REFERRED TO THE ALLERGY CLINIC? (PLEASE CHECK ONE)

☐ INSURANCE LIST, ☐ OFFICE SIGN, ☐ INTERNET, ☐ OTHER PATIENT, ☐ PHYSICIAN, ☐ NONE OF THE ABOVE

INTERNET SITE, PATIENT OR PHYSICIAN NAME: _____

ARE THERE OTHER MEMBERS OF YOUR IMMEDIATE FAMILY WHO HAVE BEEN SEEN AT THE ALLERGY CLINIC? ☐ YES, ☐ NO

IF YES, NAME: _____

PARENT / GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

☐ GUARDIAN, ☐ MOTHER (Check One): _____ (Last), _____ (First), _____ (Middle) SS#: _____

HOME PHONE: _____ DAYTIME PHONE: _____ CELL PHONE: _____

☐ GUARDIAN, ☐ FATHER (Check One): _____ (Last), _____ (First), _____ (Middle) SS#: _____

HOME PHONE: _____ DAYTIME PHONE: _____ CELL PHONE: _____

INSURANCE INFORMATION (*PLEASE BRING YOUR INSURANCE CARD AND A PHOTO ID WITH YOU TO OUR OFFICES.*)

ARE YOU INSURED? ☐ YES, ☐ NO PRIMARY INSURANCE CARRIER: _____

PHONE NUMBER FOR "ELIGIBILITY & BENEFITS" OR "CUSTOMER SERVICE": _____

INSURED'S RELATIONSHIP TO PATIENT: ☐ SELF, ☐ SPOUSE, ☐ PARENT/GUARDIAN, ☐ OTHER

OTHER'S RELATIONSHIP: _____ (PLEASE SPECIFY)

NAME OF INSURED: _____ (Last), _____ (First), _____ (Middle) DATE OF BIRTH: _____ (mm/dd/yyyy)

ARE YOU EMPLOYED? ☐ YES, ☐ NO INSURED'S EMPLOYER: _____

INSURED'S SS#: _____, INSURED'S ID#: _____, GROUP#: _____

MEDICARE RECIPIENTS ONLY

DO YOU HAVE SECONDARY INSURANCE? ☐ YES, ☐ NO

MEDICARE SECONDARY INSURANCE CARRIER: _____

PHONE NUMBER FOR "ELIGIBILITY & BENEFITS" OR "CUSTOMER SERVICE": _____

INSURED'S RELATIONSHIP TO PATIENT: ☐ SELF, ☐ SPOUSE

NAME OF INSURED: _____ (Last), _____ (First), _____ (Middle) DATE OF BIRTH: _____ (mm/dd/yyyy)

INSURED'S SS#: _____, INSURED'S ID#: _____, GROUP#: _____

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MEDICAL HISTORY

DATE: _____

PATIENT NAME: _____ (Last), _____ (First), _____ (Middle) DATE OF BIRTH: _____ (mm/dd/yyyy)

SOCIAL HISTORY

(FILL IN APPLICABLE BLANKS)

BIRTHPLACE: _____ MARITAL STATUS: ☐ M, ☐ S, ☐ D, ☐ W

PATIENT'S EMPLOYER: _____

OCCUPATION: _____

EXPOSURES AT WORK: ☐ SMOKE, ☐ CHEMICALS, ☐ ENVIRONMENTALS, ☐ OTHER _____

NAME OF SPOUSE: _____ (Last), _____ (First), _____ (Middle)

IS YOUR SPOUSE EMPLOYED? ☐ YES, ☐ NO SPOUSE'S EMPLOYER: _____

SPOUSE'S OCCUPATION: _____

OTHER FAMILY MEMBERS AT HOME - (RELATIONSHIP/AGE):

_____

EXERCISE (TYPE): _____ FREQUENCY: _____

SMOKING:
- ☐ NEVER HAVE SMOKED
- ☐ QUIT SMOKING _____ YEARS AGO (USE FRACTIONS IF APPROPRIATE)
- ☐ CURRENT SMOKER _____ PACKS PER DAY FOR _____ YEARS (USE FRACTIONS IF APPROPRIATE)
- ☐ EXPOSED TO 2ND HAND SMOKE

ALCOHOL USE:

____ DRINKS PER WEEK

DRUG USE:

RECREATIONAL USE: ☐ YES, ☐ NO

MEDICATION ALLERGIES

(PLEASE INCLUDE OVER-THE-COUNTER MEDICATIONS)

DRUG	REACTIONS

FOOD ALLERGIES

FOOD	REACTIONS

PATIENT NAME: _____, _____, _____ DATE OF BIRTH: _____
(Last) (First) (Middle) (mm/dd/yyyy)

FAMILY HISTORY
(CHECK ALL THAT APPLY)

PARENTS: ☐ ASTHMA, ☐ EMPHYSEMA, ☐ ALLERGIES, ☐ SINUSITIS, ☐ HIVES, ☐ ECZEMA
GRANDPARENTS: ☐ ASTHMA, ☐ EMPHYSEMA, ☐ ALLERGIES, ☐ SINUSITIS, ☐ HIVES, ☐ ECZEMA
SIBLINGS: ☐ ASTHMA, ☐ EMPHYSEMA, ☐ ALLERGIES, ☐ SINUSITIS, ☐ HIVES, ☐ ECZEMA
CHILDREN: ☐ ASTHMA, ☐ EMPHYSEMA, ☐ ALLERGIES, ☐ SINUSITIS, ☐ HIVES, ☐ ECZEMA

ENVIRONMENTAL HISTORY
(CHECK ALL THAT APPLY / FILL IN ALL THE BLANKS)

RESIDENCE: ☐ APARTMENT, ☐ HOUSE, AGE OF HOUSE _____ (YEARS), FLOODING ☐ NO, ☐ YES, WHEN? _____
FLOORING: **LIVING AREAS:** ☐ CARPET, ☐ TILE/WOOD **BEDROOM:** ☐ CARPET, ☐ TILE/WOOD
WINDOWS: **LIVING AREAS:** ☐ CURTAINS, ☐ BLINDS **BEDROOM:** ☐ CURTAINS, ☐ BLINDS
HEAT: ☐ CENTRAL-HEAT, ☐ RADIATOR **A/C:** ☐ CENTRAL-AIR, ☐ WINDOW-UNIT, ☐ NONE
FREQUENCY OF A/C FILTER CHANGES: EVERY _____ MONTHS
BED: ☐ MATTRESS, ☐ BOX SPRING, AGE OF BED _____ (YEARS), ☐ WATERBED, ALLERGY COVERS? ☐ NO, ☐ YES
PETS? _____, ☐ INDOOR, ☐ OUTDOOR, ☐ IN BEDROOM
(List number of pets and all pet breeds)
LIVE PLANTS INDOORS: ☐ NO, ☐ YES, WHERE? _____

PREVIOUS ALLERGY TESTING
(CHECK ALL THAT APPLY / FILL IN ALL THE BLANKS)

CLINIC: _____ PHYSICIAN: _____ WHEN: _____

ALLERGY SHOTS: ☐ NO, ☐ YES. HOW LONG? _____ DOSE/FREQ: _____

PAST MEDICAL / SURGICAL HISTORY
(CHECK ALL THAT APPLY / FILL IN ALL THE BLANKS)

DATE OF LAST PHYSICAL: _____ BY WHOM? _____

DATE OF LAST TUBERCULOSIS TEST: _____ DATE OF LAST CHEST X-RAY: _____

HAVE YOU EVER BEEN HOSPITALIZED? ☐ NO, ☐ YES.

HOSPITALIZATIONS AND SURGERIES - When/Why? _____

OTHER MEDICAL CONDITIONS: _____

IMMUNIZATIONS: CHILDHOOD UP TO DATE? ☐ YES, ☐ NO

DATE OF LAST INFLUENZA VACCINE: _____ DATE OF LAST PNEUMONIA VACCINE: _____

PATIENT NAME: _____, _____, _____ DATE OF BIRTH: _____
(Last) (First) (Middle) (mm/dd/yyyy)

PAST MEDICAL / SURGICAL HISTORY (continued)

(CHECK ALL THAT APPLY / FILL IN ALL THE BLANKS)

HEAD	**HEADACHES**: ☐ SINUS, ☐ TENSION, ☐ MIGRAINE - WHERE: _____ OTHER: _____
EARS	**INFECTIONS**: ☐ CHILDHOOD, ☐ FREQUENT, ☐ RARE/NEVER, **HEARING LOSS:** ☐ YES, ☐ NO, OTHER _____
EYES	☐ GLASSES, ☐ CONTACTS, ☐ LASIK SURGERY, ☐ GLAUCOMA, ☐ CATARACTS OTHER: _____
NOSE	☐ NASAL ALLERGIES, ☐ SINUS INFECTIONS ____ PER YEAR, ☐ NASAL POLYPS ☐ SINUS SURGERY, OTHER: _____
LUNGS	☐ ASTHMA ER VISITS FOR ASTHMA ____ TIMES, HOSPITALIZED FOR ASTHMA ____ TIMES, INTUBATED FOR ASTHMA ____TIMES ☐ PNEUMONIA ____ TIMES ☐ BRONCHITIS ____ TIMES ☐ TUBERCULOSIS ☐ BRONCHIECTASIS OTHER: _____
HEART	☐ HIGH BLOOD PRESSURE, ☐ HIGH CHOLESTEROL, ☐ HEART ATTACK, ☐ HEART MURMUR, ☐ ARRHYTHMIA, ☐ FAILURE OTHER: _____
GASTRO-INTESTINAL	☐ HEARTBURN, ☐ ACID REFLUX, ☐ HIATAL HERNIA, ☐ ULCERS, ☐ IRRITABLE BOWEL, ☐ CROHN'S DISEASE, ☐ ULCERATIVE COLITIS OTHER: _____
GENITAL-URINARY	☐ YEAST INFECTIONS W/ANTIBIOTICS, ☐ DIFFICULTY URINATING W/ANTIHISTAMINES OR W/DECONGESTANTS OTHER: _____
SKELETAL	☐ OSTEOPOROSIS, ☐ OSTEOARTHRITIS, ☐ RHEUMATOID ARTHRITIS OTHER: _____
OTHER	☐ DIABETES, ☐ KIDNEY DISEASE, ☐ THYROID DISEASE ☐ SLEEP APNEA, CPAP ☐ YES, ☐ NO, ☐ CANCER - Type: _____ OTHER: _____
STINGS/BITES	INSECTS: _____ TYPE OF REACTION: ☐ LOCAL SWELLING, ☐ DIFFICULTY BREATHING, ☐ HIVES

PATIENT NAME: _____, _____, _____ DATE OF BIRTH: _____
(Last) (First) (Middle) (mm/dd/yyyy)

CURRENT MEDICATIONS

(PLEASE INCLUDE OVER-THE-COUNTER MEDICATIONS, VITAMINS AND SUPPLEMENTS)

MEDICATION (INCLUDING EYE DROPS)	STRENGTH	DOSE

NOTICE OF MEDICAL PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be 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, or 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:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, 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.

This notice is effective as of January 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 to make the new notice provision 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 provision of this notice or the polices and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information at:	**For more information about HIPAA or to File a complaint:**
Houston Allergy and Asthma Clinic 1200 Binz, Suite 180 Houston, TX 77004 713.522.9911 Or The Allergy Clinic 4600 Fairmont Parkway, Suite 107 Pasadena, TX 77504 281.991.6750	The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, DC 20201 202.619.0257 Toll Free: 1.877.696.6775

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NOTICE OF MEDICAL PRIVACY PRACTICES ACKNOWLEDGEMENT

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 care 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 acknowledge that I have received your NOTICE OF MEDICAL PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF MEDICAL 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 MEDICAL PRIVACY 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 restriction, but if you do agree, then you are bound to abide by such restrictions.

ACCOUNT #: _____

PATIENT NAME: _____, _____, _____
(Last) (First) (Middle)

IF PATIENT IS A MINOR:

PARENT OR GUARDIAN (PRINTED NAME): _____, _____ _____
(Last) (First) (Middle)

SIGNER'S RELATIONSHIP TO PATIENT: ☐ SELF, ☐ PARENT, ☐ LEGAL GUARDIAN, ☐ OTHER _____

DATE: _____

PATIENT OR LEGAL REPRESENTATIVES SIGNATURE: _____

OFFICE USE ONLY

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

REASON: _____

NAME: _____, _____ _____
(Last) (First) (Middle)

SIGNATURE: _____ DATE: _____

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PATIENT CONSENT FOR DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications be made by alternative means, such as sending correspondence to the individual's office, instead of the home.

ACCOUNT #: _____

PATIENT NAME: _____ (Last), _____ (First), _____ (Middle)

HOME PHONE: _____

☐ OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

DAYTIME PHONE: _____

☐ OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

CELL PHONE: _____

☐ OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

ALT. PHONE: _____, ☐ CELL, ☐ WORK, ☐ OTHER, _____ (PLEASE SPECIFY)

☐ OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

AUTHORIZED PERSONS THAT CAN OBTAIN MY PERSONAL HEATH INFORMATION:

NAME: _____ (Last), _____ (First), _____ (Middle) RELATIONSHIP: _____

NAME: _____ (Last), _____ (First), _____ (Middle) RELATIONSHIP: _____

NAME: _____ (Last), _____ (First), _____ (Middle) RELATIONSHIP: _____

IF PATIENT IS A MINOR:

PARENT OR GUARDIAN (PRINTED NAME): _____ (Last), _____ (First) _____ (Middle)

SIGNER'S RELATIONSHIP TO PATIENT: ☐ SELF, ☐ PARENT, ☐ LEGAL GUARDIAN, ☐ OTHER _____

DATE: _____

PATIENT OR LEGAL REPRESENTATIVES SIGNATURE: _____

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FINANCIAL POLICY

Welcome and thank you for choosing THE ALLERGY CLINIC for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe these fees are reasonable and reflect other area physician's charges. We are pleased to discuss with you any questions that you may have concerning your bill. Providing quality care is our primary concern.

Regarding Insurance: Indemnity and Private Insurance Policies: THE ALLERGY CLINIC will file claims directly with your insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee your insurance carrier will pay for services. Payment of co-insurance, deductibles, or non-covered services, when applicable, is required at the time of service.

Contracted Managed Care Plans (HMO, PPO, POS, EPO): Each time you make an appointment with an Allergy Clinic physician, it is your responsibility to make sure the physician is currently under contract with your plan and you have obtained the necessary referrals. Verification of your plan benefits/ coverage is required. Often this verification requires us to share the reason for your visit with the managed care plan. Payment of co-payments, co-insurance, deductible or non-covered services, when applicable, is required at the time of service.

We allow 45 days from the date a claim is filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you are responsible for the entire balance, without further notice. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. You are responsible for the timely payment of your account.

Medicare: The Allergy Clinic accepts assignment of Medicare benefits. We will file for Medicare supplement insurance if your plan is set up as an automatic cross-over by Medicare. See Medicare Signature on File Authorization Form.

Minors Accompanied by an Adult: The parent(s) or guardian(s) accompanying a minor is responsible for providing current insurance information for the minor and/or payment in full for services provided.

Unaccompanied Minors: A minor must have authorization for medical treatment signed by a parent or guardian and is responsible for providing current insurance information for self and/or payment in full for services provided.

To assist us in establishing your Allergy Clinic account, please (1) provide current patient and insurance information and (2) authorize release of information necessary for insurance filing and pre-certification by signing the statement below. Your payment can be in the form of cash, check Visa/MasterCard, Discover or American Express.

Insurance Assignment and Authorization to Release Information

Patient Name: _____ (Last), _____ (First), _____ (Middle)

Name of Policy Holder: _____ (Last), _____ (First), _____ (Middle)

I request payment of authorization Medicare/Medigap/Other insurance company benefits be made on my behalf to The Allergy Clinic for any services furnished be by that party who accepts assignment/physician. Regulations pertaining to Medicare Assignment of Benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financial Administration or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the above mentioned party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801 -3812 provides penalties for withholding this information).

Policy Holder Signature: _____ Date: _____

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CONFIDENTIAL HEALTH INFORMATION FAX

This transmission contains personal health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

TO: **THE ALLERGY CLINIC**

LOCATION: **(CHECK ONE)**

☐ FANNIN	☐ PASADENA	☐ PEARLAND	☐ MUSEUM DISTRICT
Texas Medical Center 7707 Fannin, Suite 100 Houston, Texas 77054 Phone: (713) 797-0993 Fax: (713) 797-6649	4600 Fairmont Pkwy, Ste 107 Pasadena, TX 77504 Phone: (281) 991-6750 Fax: (281) 991-7611	10223 FM 518, Suite L Pearland, Texas 77584 Phone: (713) 436-9009 Fax: (713) 436-6729	1200 Binz, Suite 180 Houston, Texas 77004 Phone: (713) 522-9911 Fax: (713) 522-6052

Attention: _____

Phone Number: _____

Fax Number: _____

FROM: Name: _____

Phone Number: _____

Fax Number: _____

Fax Send Date: _____ Time: _____ Number of Pages: _____
(Including Cover Page)

Remarks:

_____

_____

_____

_____

WARNING: This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.