



# Allergy & Asthma Associates of Allen

## Notices 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.**

### Uses and Disclosures

#### Treatment

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation of your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that they can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

#### Payment

Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

#### Healthcare Operations

Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

#### Law Enforcement

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with governmental mandated reporting.

#### Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

#### Research

Under certain circumstances, we may use and disclose health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication or treatment to those who received another, for the same condition. Before we use or disclose health information for research, the project will go through a special approval process. This process evaluates a proposed research project and its use of health information to balance the benefits of research with the need for privacy of health information. We may also permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

#### Other Uses and Disclosures Require your Authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

#### Appointment Reminders

Your health information will be used by our staff to send you appointment reminders via telephone, electronic mail, and/or the US mail.

#### Address:

977 Raintree Circle, Ste 100,  
Allen, Texas 75013

[www.allenallergy.com](http://www.allenallergy.com)

Phone: (972) 747-7007

Fax: (972) 747-7006



# Allergy & Asthma Associates of Allen

## Information about Treatments

Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

## Individual Rights

You have certain rights under the federal privacy standards.

These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

## Practice Duties

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

We also are required by law to abide by the privacy policies and practices that are outlined in this notice.

## Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Upon request, we will provide you with the most recently revised notice of privacy practices. These revised policies and practices will be applied to all protected health information we maintain.

## Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your medical records by contacting the office manager or privacy officer listed below. Your request will be reviewed and will generally be approved unless there is a legal or medical reason to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

## Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address show below. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

## Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer  
Dr. Hari Reddy  
977 Raintree Circle, Ste 100  
Allen, Texas 75013

## Effective Date

This Notice is effective on or after November 11, 2020.

Address:

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# Allergy & Asthma Associates of Allen

Patient: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Work Address: \_\_\_\_\_ Email: \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Identification #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insurance Telephone Number (Benefits line or Member's Services): \_\_\_\_\_

## Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in this notice. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

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# Allergy & Asthma Associates of Allen

## FINANCIAL OFFICE POLICY

Thank you for choosing our practice as your healthcare provider. Your clear understanding of our Financial Policy is important to our professional relationship. Please speak with the office manager if you have any questions regarding this policy.

### **PAYMENT IS EXPECTED AT THE TIME OF SERVICE**

Payment is required at the time services are rendered unless other arrangements have been made in advance. Such payments include coinsurance, co-payments, deductibles, and non-covered services for participating insurance companies. We accept cash, credit/debit cards and personal checks. There is a \$25.00 service charge on all returned checks. If the patient is a minor, the parent/guardian who brings the child in for a visit is the responsible party.

### **INSURANCE/ FINANCIAL AGREEMENT**

I understand that I am required to give my current insurance card, driver's license, and billing information for insurance to be filed on my behalf. I also understand that I will notify Allergy & Asthma Associates of Allen of any changes in my insurance or billing information. If accurate billing and insurance information is not given then I will be responsible for all charges incurred due to timely filing requirements by my insurance company. I am also responsible for services denied by my insurance company as "non-covered" or "not medically necessary." I authorize the treatment of the person named above and agree to pay for all fees for such treatment. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pending of such claims and that all proceeds of insurance will be assigned to this office. I authorize the release of any medical information necessary to process insurance claims and also request payment of government benefits either to me or the party that accepts assignment below. If we are not contracted with your insurance company, you will be required to pay in full at the time of service.

### **REFERRALS**

If you are on an insurance plan that requires a referral, it is your responsibility to obtain a referral for your visits. The referral must be requested from your primary care physician prior to your appointment in order for insurance to be filed.

### **APPOINTMENTS**

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. There will be a \$25 fee for missed appointments.

### **FORMS/PRESCRIPTIONS**

School/Camp/Physical forms may be mailed, faxed or dropped off to our office. We require 24-48 hours notice for completion. We are happy to mail, fax or hold them for you to pick them up. For written prescriptions, please allow 24 hours for completion.

### **IMMUNOTHERAPY**

All patients receiving allergy injections must wait in the waiting room at least 25 minutes following each injection. We do ask that you pay your co-pay/co-insurance portion when you receive your injection. When a new vial of serum needs to be made, we do require you to clear any balance before processing the vial.

### **MEDICAL RECORDS**

We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Medical records will be completed within 15 business days as mandated by the Texas Medical Board and may be subject to a processing fee as determined by the Board.

I have read and understand Allergy & Asthma Associates of Allen's Financial Policy. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collection.

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

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# Allergy & Asthma Associates of Allen

## Medical History

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: ☐ Male ☐ Female

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Reason for visit: ☐ Seasonal Allergy ☐ Year- Round Allergies ☐ Food Allergies ☐ Asthma ☐ Cough ☐ Sinusitis ☐ Hives ☐ Rash  
☐ Eczema ☐ Insect Allergy ☐ Drug allergy ☐ Recurrent Infection ☐ Other: \_\_\_\_\_

Duration of Condition: \_\_\_\_\_

List all medications you have tried in the past for allergies:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy's Address and Phone Number: \_\_\_\_\_

Have you ever had allergy skin testing? ☐ Yes ☐ No

Date of testing: \_\_\_\_\_

Physician's name: \_\_\_\_\_

Have you ever been on allergy shots? ☐ Yes ☐ No

Have you had recurrent sinusitis? ☐ Yes ☐ No

If Yes, Frequency: \_\_\_\_\_

If Yes, Date(s): \_\_\_\_\_

Have you had recent pneumonia or bronchitis? ☐ Yes ☐ No

Have you ever had a sinus X-ray or CT? ☐ Yes ☐ No

If Yes, Frequency: \_\_\_\_\_

If Yes, Dates: \_\_\_\_\_

Have you ever been diagnosed with asthma? ☐ Yes ☐ No

Have you ever been hospitalized with asthma? ☐ Yes ☐ No

Have you had to use recent oral or injectable steroids? ☐ Yes ☐ No

If Yes, Frequency: \_\_\_\_\_

Have you been on antibiotics in the last 6 months? ☐ Yes ☐ No

If yes, please list which one: \_\_\_\_\_

List family members with allergy problems: \_\_\_\_\_

Have you tested positive for: ☐ HIV ☐ Hepatitis B ☐ Hepatitis C

Are you current on your flu vaccine? ☐ Yes ☐ No

Are you current on general vaccines? ☐ Yes ☐ No

### Social History:

How long have you lived in your current home? \_\_\_\_\_ years

Is there an obvious mold problem? ☐ Yes ☐ No

If yes, where is the mold in the home? \_\_\_\_\_

Type of flooring (include bedroom): \_\_\_\_\_

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Are you a current smoker/tobacco user? ☐ Yes ☐ No

If yes, how many packs per day \_\_\_\_\_ how long? \_\_\_\_\_

Are you a former smoker/tobacco user? ☐ Yes ☐ No

If yes, when did you quit? \_\_\_\_\_

Prolonged cigarette smoke exposure? ☐ Yes ☐ No

Alcohol consumption: ☐ Never ☐ Socially ☐ Weekly

Occupation: \_\_\_\_\_

Hobbies: \_\_\_\_\_

**Pets:** ☐ Dog ☐ Cat ☐ Other: \_\_\_\_\_

They live: ☐ Indoor ☐ Outdoor ☐ Both

## Review of Systems: Please check all the symptoms you may have

**General:** ☐ fever ☐ weight loss ☐ fatigue ☐ problems sleeping ☐ missed school/work ☐ night sweat

**Nose:** ☐ clear nasal drainage ☐ nasal congestion ☐ sneezing ☐ nasal itching ☐ yellow/green nasal drainage ☐ loss of smell ☐ snoring  
☐ bleeding ☐ loss of taste

**Throat:** ☐ post-nasal drip ☐ sore ☐ itch ☐ hoarseness ☐ trouble swallowing

**Eyes:** ☐ itching ☐ clear drainage ☐ yellow/green eye drainage ☐ redness ☐ current infection ☐ swelling

**Sinus:** ☐ sinus pain forehead ☐ sinus pain cheekbone ☐ current sinus infection

**Ears:** ☐ congestion ☐ pain ☐ hearing loss ☐ current ear infections

**Chest:** ☐ asthma ☐ chronic cough ☐ shortness of breath ☐ chest tightness ☐ current pneumonia/bronchitis

**Skin:** ☐ eczema ☐ dry ☐ itchy ☐ contact dermatitis ☐ hives ☐ angioedema (swelling) ☐ current skin infection

**Hematology:** ☐ lymph node problems ☐ bleeding problems ☐ bruising problems

**GI:** ☐ nausea ☐ vomiting ☐ reflux ☐ lactose intolerance ☐ difficulty swallowing ☐ change in bowel habits ☐ blood in stool

**Endocrine:** ☐ weight gain ☐ weight loss ☐ cold or heat intolerance ☐ excessive thirst

**GU (urinary):** ☐ current/history of infection ☐ kidney problems ☐ incontinence ☐ back pain ☐ blood in urine

Past Medical History (including chronic problems):

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History of Surgery (include sinus surgery):

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Do you have any known allergies to medications? ☐ Yes ☐ No

Do you have a known latex allergy? ☐ Yes ☐ No

If yes, please list names and symptoms: \_\_\_\_\_

Do you have an: ☐ Epi-Pen ☐ Auvi-Q ☐ other: \_\_\_\_\_

All current medications: please list dosage (include allergy medications):

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## (Women only)

Are you currently or might be pregnant? ☐ Yes ☐ No

Are you planning or attempting to become pregnant in the near future? \_\_\_\_\_

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# Allergy & Asthma Associates of Allen

## ALLERGY SKIN TEST CONSENT FORM

The most often used method for skin testing is the skin prick test. This test exposes you to tiny amounts of items to which you may be allergic. If you are allergic to a substance, a reaction will appear. The doctor and/or nurse will examine any bump that appears and the reddened area around it to decide whether a positive reaction has occurred indicating an allergy.

In the prick test, allergens are applied by tiny scratches that penetrate only the very top layer of skin and rarely draw blood. You may feel only a slight prick or scraping of the skin. If just a few tests are being given, the arm may be used. Reactions are usually seen in ten to twenty minutes if they are going to occur.

Reactions to testing can include an itchy rash that may last for several days and rarely (less than 1% of patients) – hives, swelling, sneezing, shortness of breath/anaphylaxis and light headedness.

*The risk and benefits of allergy skin testing have been explained by my doctor and the staff. I am satisfied with the explanation that has been given and do not desire further information. I give permission and consent for this procedure and any treatment needed as a result of this procedure.*

**\*\*IN ORDER TO AVOID COMPLICATIONS AND/OR INTERACTIONS PLEASE INFORM THE NURSE IF YOU HAVE HAD A MEDICATION CHANGE OR AN ADDITION TO YOUR REGIMEN SINCE THE PREVIOUS OFFICE VISIT.**

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Patient or Guardian)

\_\_\_\_\_  
Witness



# Allergy & Asthma Associates of Allen

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Confidential Voicemail Authorization

- Occasionally, it may become necessary to contact our patient(s) by telephone. In the event you are not available by phone, we will leave detailed voice messages regarding you/your child's treatment. By providing your telephone number(s), you hereby grant Allergy & Asthma Associates of Allen Permission to leave detailed voicemail messages regarding you/your child's treatment.

My Cell Phone: \_\_\_\_\_

☐

I do **NOT** wish to receive voicemails regarding me/my child's treatment.

- I give permission for Allergy & Asthma Associates to provide my personal healthcare information to:

Name: \_\_\_\_\_ (relationship to patient): \_\_\_\_\_

Name: \_\_\_\_\_ (relationship to patient): \_\_\_\_\_

## E- Mail Messaging Authorization

Email: \_\_\_\_\_

- Emails sent by Allergy & Asthma Associates of Allen are **NOT** SPAM.
- Emails sent to you will be items regarding you/your child's treatment or appointment.

☐

I do **NOT** wish to receive emails from Allergy & Asthma Associates of Allen

## Text Message Authorization

My Cell Phone: \_\_\_\_\_

☐

I do **NOT** wish to receive text message reminders regarding future appointments

## Mailing address

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
*Patient's Printed Name*

\_\_\_\_\_  
*Patient's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*\*Legal Representative's Printed Name*

\_\_\_\_\_  
*Legal Representative's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*\*If Representative, Specify Relationship to Patient.*