ALLERGY & ASTHMA
CENTER OF TEXAS

John B. Meiser, M.D., P.A.

Please complete and sign this form so we can verify that your information is correct.

Patient Last Name: _____ Patient First Name: _____

DOB: ____/____/____ SS #: _____ Driver License #: _____ State: _____

Address: _____

City: _____ State: _____ Zip Code: _____

HM #: _____ WK #: _____ Cell #: _____

Email _____

Employer: _____Occupation: _____

Mother's Name (if minor) _____Preferred phone _____

Father's Name (if minor) _____Preferred phone _____

INSURANCE INFORMATION:

Policy Holder's Name: _____ DOB: ____/____/____

Relationship to Patient: _____ Policy Holder Insurance ID #: _____

Policy Holder Address: _____

City: _____ State: _____ Zip Code: _____

Policy Holder Employer: _____

Primary Insurance Plan (Present Actual Card): _____

Secondary Insurance Plan (Present Actual Card): _____

Emergency Contact Name: _____ Relationship: _____

HM #: _____ WK #: _____ Cell #: _____

I hereby assign to Allergy & Asthma Center of Texas all of my right, title and interest of the insurance/health and welfare benefits otherwise payable to me. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assigned to release all information necessary to secure payment.

Signature: _____ Date: ____/____/____

PLEASE PRESENT INSURANCE CARD(S) AND DRIVER LICENSE TO THE RECEPTIONIST WITH YOUR COPAY.

ALLERGY & ASTHMA
CENTER OF TEXAS
John B. Meiser, M.D., P.A.

Today's Date: ____/____/____

Health Information Sheet

Patient's Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____

How were you referred to Dr. Meiser? _____

Pharmacy name: _____ Location (City and Cross Streets): _____

Please describe the reason for the visit today: _____

_____

_____

Past Medical History – Please list **ALL** past medical problems:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Surgical History – Please list all past surgeries and the date that they were performed:

1. _____ 3. _____
2. _____ 4. _____

Allergy History – Are you allergic to any **food, medicine, chemical, latex, insects, and/or other?** YES ☐ NO ☐

If yes, please list: _____

_____

Family History – Please list medical problems experienced by patient's family members: (Include allergy/asthma/eczema/immune problems)

Mother's Side: _____

Father's Side: _____

Social History – Please answer the following questions:

Do you have pets? NO ☐ YES ☐ If yes, what type and how many? _____

Do you currently smoke or have you smoked in the past? NO ☐ YES ☐ If yes, how long? _____

Do you consume alcohol? NO ☐ YES ☐ If yes, how many drinks per week? _____

Do you exercise? NO ☐ YES ☐ If yes, what type of exercise? _____ How often? _____

Are you exposed to mold/fumes/strong odors/chemicals? NO ☐ YES ☐ If yes, where/what? _____

Review of Systems – Please circle any signs/symptoms/conditions that you currently experience:

Chest:	fast heart rate	palpitations				
Constitutional:	chills	fatigue	fever	night sweats		
Ears:	discharge	ear congestion	ear itching	earache	hearing loss	vertigo
Mouth and Throat:	dry mouth	sore throat				
Endocrine:	cold intolerance	heat intolerance	increased thirst	weight gain	weight loss	
Eyes:	blurred vision	itch	redness	watery		
Frequent infections:	bronchitis	ear (otitis)	pneumonia	sinusitis	skin	
GI:	diarrhea	heartburn	reflux	trouble swallowing	vomiting	
Hematology:	swollen lymph nodes	unusual bleeding	unusual bruising			
Musculoskeletal:	muscle pain	red/swollen joints	stiff/sore joints			
Neurologic:	headaches	numbness	weakness			
Nose:	congestion	itch	loss of smell	runny	sneezing	snoring
Psychology:	anxious	depressed	stressed			
Respiratory:	cough	croup	shortness of breath	tight chest	wheeze	
Sinus:	pain	post nasal drip	pressure			
Skin:	dry	hives	itch	rash	swelling	

Current Medication – Please list current medicines including **dose and directions.** (Over the Counter, prescription medicine and herbal remedies)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

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Patient Preference Regarding Communication of Health Information

I. How to Contact

I wish to be contacted in the following manner:

OK to leave message with detailed information at the following phone numbers:

- ☐ Home _____
- ☐ Cell _____
- ☐ Work _____

I prefer to receive confirmation of my appointment via

- ☐ Email _____
- ☐ Phone _____

II. Who to Contact

I hereby give permission to Allergy & Asthma Center of Texas to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship

_____ I do not wish to disclose any information with anyone other than my insurance company as provided in Allergy & Asthma Center of Texas' Privacy Policy or as required by law.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____ / _____ / _____

Patient Name Date

_____

Signature (Responsible Party)

ALLERGY & ASTHMA
CENTER OF TEXAS

Financial Policy Agreement

This Financial Policy Agreement (the "agreement"), is by and between Allergy & Asthma Center of Texas, ("us" or "we") and the undersigned patient ("you" or "yours"). Now therefore, in consideration of the services rendered and to be rendered and other good and valuable consideration, the receipt and sufficiency of which you acknowledge, you and we agree as follows:

Payments: You agree to pay us the fees we charge to your account for services and goods. The balance on your account as reflected in the statement we provide to you is due and payable in full when the statement is issued and is past due if not paid within 15 days. The word "account" means the account that has been established in your name to which charges are made and payments credited. By executing this agreement, you agree to be financially responsible for all services that are rendered to your account.

Monthly statement: If you have a balance due on your account, we or our billing office will send you a monthly statement.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

Required Payment(s): As required by your insurance carrier, any co-payment must be paid at the time of service.

Payment Options if you have no insurance:

1. You may choose to pay by cash, check, or credit card on the day that treatment is rendered. If you are paying for treatment in full, we offer a cash discount at the time of service.
2. If financial arrangements are needed, please speak with a member of the front office staff to discuss your options.
3. You may secure other third party financing for the entire amount and make payments to the lending institution.

Payment Options if you have insurance:

1. You may choose to pay your deductible and any out-of-pocket portions at the time of service by cash, check, or credit card.
2. If financial arrangements are needed, please speak with a member of the front office staff to discuss your options.

Insurance: The terms of your insurance coverage are a contract between you and your insurance company. We call to verify your benefits as a courtesy to our patients and we do our best to provide accurate information. Final determination of payment is made by your insurance company and should be addressed directly with them if you feel there is a discrepancy between your bill and your expected benefits.

Your doctor is contracted with most local insurance plans. It is your responsibility, however, to make sure your doctor is a contracted provider with your insurance. If your insurance requires a referral and/or pre-certification, we will assist you, but it is your responsibility to make certain this has been done prior to the date of treatment. Failure to obtain the referral/pre-certification required by your insurance carrier may result in lower payment or no payment by your insurance company.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to collection, you agree to pay any and all of the collection costs, including without limitation, all attorney fees and costs and a late fee of $20 which will be applied to your account for missed payments.

Divorce: In case of divorce or legal separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor child will then be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Initials: _____ Date: _____

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www.AACTMD.com
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F: (972) 377-9906

ALLERGY & ASTHMA
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Returned Checks: There is a fee of $30 for any check returned by your bank. You agree to pay this fee, in addition to the amount of the returned check, by cash, money order, certified check, or credit card within 5 business days.

Waiver of Confidentiality: You understand that if your account is submitted to an attorney or a collection agency or if your past due account status is reported to a credit agency, the fact that you have received treatment at this office may become a matter of public record.

Contracted Lab: It is your responsibility to know which lab your insurance is contracted with prior to your appointment. This is to insure lab work and/or requisitions are sent to the correct lab.

COBRA: If at any time during your care your insurance benefits are considered to be COBRA, we need to be notified immediately. You must provide proof of current coverage at each visit, and you will be responsible for payment in full if your insurance company cannot verify the coverage for the dates of treatment.

Missed Appointment Fee: The 2nd time a patient does not show up for his/her appointment and/or cancels with less than a 24 hour notice, a $25 fee may be charged. We will not file this fee with your insurance company; you are responsible for the payment of this fee. Patients with three or more missed appointments may be asked to transfer their care.

Worker's Compensation, Medicaid, and Medicare: At this time our office has chosen not to accept these plans as payment for treatment.

Transfer of Records: You will need to sign a Medical Records Release form to have copies of your medical records sent to another doctor and/or organization. By releasing your medical records you authorize us to release all relevant information including HIV status. This may include payment history if used for legal purposes. If you would like a copy of your own medical records, there will be a $25 fee.

Co-Signature: In special circumstances a co-signature may be required. If this or any other Financial Agreement is signed by another party, that co-signature remains in effect until canceled in writing. When written cancellation is received, the co-signature becomes ineffective for any subsequent charges.

Credit Reporting: You authorize us to procure a consumer report and credit check on you and to report any matters to such credit reporting bureaus as we may determine. You consent to the release of such information orally or in writing, and hereby release any and all parties from all liability, claims and damages for any errors or other claims based upon any statements we make to any person.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions herein and this agreement will be in full force and effect.

I hereby authorize payment of medical benefits directly to Allergy & Asthma Center of Texas and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Allergy & Asthma Center of Texas. I further understand should my account become delinquent, I shall pay the attorney fees or collection expenses of Allergy & Asthma Center of Texas, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I am responsible for payment of services in full before the services are rendered.

_____
Patient Name

_____
Signature (Responsible Party)

_____ / _____ / _____
Date

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Notice of Privacy Practices

Notice of Privacy Practices: You have been provided a copy of our Notice of Privacy Practices. A copy of our Notice of Privacy Practices is also posted on our website and available at our office. Our office complies with **HIPAA (Health Insurance Portability and Accountability Act of 1996)** and all federal and state laws governing the privacy of your information. If you have any questions regarding the information in the Notice, please contact the representative designated in the Notice.

Use of Information: By signing this form, you consent to our use and disclosure of your Protected Health Information (PHI) to carry out Treatment, Payment activities, and Healthcare Operations (TPO). You are also acknowledging receipt, understanding and agreement to our Notice of Privacy Practices. The duration of this consent is indefinite and continues until revoked in writing.

You may refuse to sign this authorization.

_____

Patient Name DOB

_____

Signature (Responsible Party)

_____ / _____ / _____

Date

ALLERGY & ASTHMA
CENTER OF TEXAS

Consent to Treat

I hereby authorize Allergy & Asthma Center of Texas and its employees and agents, including physicians, physician assistants, medical assistants and nurse practitioners to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians, including consultants, associates, and assistants of the physicians' choice.

_____

Patient Name DOB

_____

Signature (Responsible Party) Date

If patient is a minor, and you want to designate another party to accompany patient to office visit, allergy injection, procedure, etc., please complete section below:

I consent and authorize _____ to also consent to and authorize evaluation and treatment for my child_____ when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures for the child named herein. The duration of this consent is indefinite and continues until revoked in writing.

_____

Signature Date