



**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 COPY.**



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:

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



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
_____ Name	_____ Relationship
_____ 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)

## Consent to Treat

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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Patient, Parent/Guardian)

## Minors

Minors under the age of 18 will not be seen without a parent, guardian or another designated party (Consent to treat minor form must be on file for any designated party). Appointments will be rescheduled if a parent is not present at the time of the appointment. No exceptions.

## ePrescription History Consent

Our office utilizes ePrescriptions to reduce medication errors and enhance patient safety. One optional feature of this service is the ability to obtain your list of medications from your pharmacy benefit manager using the SureScripts service.

I authorize Allergy & Asthma Center of Texas to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions for the past few years.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Patient, Parent/Guardian)

\_\_\_\_\_  
Patient declines ePrescription history

## Appointment Cancellations/No Shows

We reserve your appointment exclusively for you. Please understand that last minute cancellations prevent other patients from being scheduled. Allergy & Asthma Center of Texas classifies a "no show" patient as those who fail to present to the office at the time of their appointment or give 24 hours notice of cancellation or rescheduling. Note: We request AT LEAST 24 hours notice for cancellation of a regular office visit and 48 hours for cancellation or reschedule of a Procedure visit.

### Cancellation/No Show Fees:

1. Follow up visits/Urgent visits/Xolair visits/New Patient visits – Cancellations or reschedules without 24 hours notice and no shows will be assessed a \$50 fee.
2. RUSH/Food & Drug Challenges/Cluster – Cancellations or reschedules without 48 hours notice and no shows will be assessed a \$75 fee.

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.

## Late Arrivals

We reserve the right to cancel your appointment if you present more than 10 minutes past your reserved appointment time. Patients who miss their appointment due to being late will be assessed the above missed appointment fees.

## Financial Policy Agreement

The exact amount that your insurance company will pay for your claims cannot be determined with complete accuracy until the claim has been filed with your insurance company and they have processed it. We will verify services being rendered with your insurance company and give you an estimate. Any amount that your insurance company estimates is your responsibility, i.e. copay, deductible or co-insurance, and will be due at the time of service.

**Payments:** We accept cash, check, Visa, MasterCard, Discover and American Express.

**Past Due Accounts:** Any accounts over 60 days past due will be transferred to a collection agency. A \$30 fee will be added to your account for the costs associated with collections. Past due balances must be paid in full before any future appointments can be scheduled.

**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 determined 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.

**Returned Check Fee:** A \$30 fee will be charged for any check returned by your bank.

**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 (presenting with the patient) 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.

## 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Patient, Parent/Guardian)

## Acknowledgement

I have read and understand the above policies of Allergy & Asthma Center of Texas. I agree to the policies above and understand that I am responsible for payment for services I receive. This form must be signed to be seen at the Allergy & Asthma Center of Texas.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Patient, Parent/Guardian)