



# NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

## REGISTRATION FORM & POLICIES (Please Print Legibly)

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

How did you hear about us: \_\_\_\_\_ E-mail: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Contact #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Marital Status: child S M W D

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy address: \_\_\_\_\_ Pharmacy #: \_\_\_\_\_

### **INSURANCE POLICY HOLDER (if different from above):**

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

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**PLEASE ALLOW US TO MAKE COPIES OF YOUR INSURANCE CARD AND TO TAKE A PICTURE OF YOU. WE KINDLY REQUEST THAT YOU NOTIFY US PROMPTLY OF ANY INSURANCE CHANGES. PLEASE INITIAL AFTER REVIEWING EACH SECTION.**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONDITIONS OF TREATMENT:** I (we) acknowledge that I (we) have been provided and have reviewed the Notice of Privacy Practices (dated March 1, 2023) and Conditions of Treatment. I (we) understand that as part of my healthcare, North Texas Allergy & Asthma Associates ("NTAAA") originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I (we) understand that this information is utilized to plan my (our) care and treatment, to bill for services provided to me (us), to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals and as required or permitted by law without my (our) consent. The Notice of Privacy Practices provides specific information and complete description of how my (our) personal health information may be used and disclosed. I (we) understand that NTAAA reserves the right to change the Notice of Privacy Practices and will notify me (us) when a revised Notice of Privacy Practices is available.

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION:** I (we) authorize NTAAA to release my (our) medical information and/or individually identifiable health information to me (us) or my (our) duly authorized representative (as noted below), representatives of local, state, or federal agencies and insurance companies or other organizations or entities as may be required or permitted under federal or state law or as may be required for review or payment of claims. I (we) further authorize NTAAA to release such information to providers, hospital, or healthcare providers needing such information to treat me (us) or to review my treatment. I (we) understand that the specific information to be released may include, but is not limited to, history, diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I (we) also understand that this authorization may be revoked by me by a written and dated notice, except to the extent that disclosure of information has been made prior or receipt of such revocation.

Below is a list of persons, whom we may inquire and/or be informed about your general medical information, conditions, or diagnosis.

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Information allowed to be released to above (please check):  All health information, OR

Visit Notes  Billing Inquiries  Diagnostic Results  General Calls  Consultation Reports  Other: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Information allowed to be released to above (please check):  All health information, OR

Visit Notes  Billing Inquiries  Diagnostic Results  General Calls  Consultation Reports  Other: \_\_\_\_\_

**AUTHORIZATION TO MAIL, CALL, TEXT OR E-MAIL:** I (we) hereby authorize NTAAA providers and staff to leave a detailed message regarding lab results or other clinical information related to my (our) care. This authorization allows NTAAA to contact me (us) by telephone at any number associated with the account, including wireless telephone numbers, and emails so that NTAAA can service the account or collect any amounts owed. I (we) may also be contacted through text messages or emails and the method of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

**INSURANCE AND PAYMENT ACKNOWLEDGEMENT:** Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and financial arrangements. Your clear understanding of our financial policies is important to our professional relationship. We participate and accept assignment for most insurance plans in the area. We submit claims to Medicare, Tricare, PPO, HMO, EPO, POS or any other insurance (excluding Medicaid as we do not participate in this program) on your behalf. **It is essential that you ensure we are a participating provider and provide us with your complete and accurate insurance information at the time your appointment is made.** It is important that all your insurance plan's requirements are met prior to providing services. This may include your payment of copays, deductibles, and any non-covered services at time of rendered service, and that pre-authorizations and required referrals are obtained prior to service. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company requires an authorization or referral, it is the patient's responsibility to obtain this for the initial visit and for continuation of care (but we will assist where possible). It is your responsibility to pay for all services provided that are not covered by your insurance. That includes amounts denied or not covered by your insurance plan. We are happy to provide any services you need, but if your insurance plan does not cover a specific service, you will be required to self-pay for these non-covered services. If we have not received your payment from your insurance plan by 45 days after the date of service or the insurance plan has denied in full or part, we will bill the balance to you. Please contact our billing office if you have any additional questions about our fees, financial policies, your insurance coverage, or financial responsibilities.

**ASSIGNMENT OF BENEFITS:** I hereby assign all medical benefits to which I am entitled to NTAAA, and I authorize NTAAA to release any information required to process claims, unless rescinded by me in writing. I authorize payment of medical benefits to NTAAA for services performed.

**PATIENT PAYMENTS:** Payments of copays, deductibles, and non-covered services are expected at the time of service. Patients without insurance are expected to make payment or other arrangements ideally prior to the service being performed. We accept cash, checks, credit cards and health savings accounts (HSA). Checks returned for non-sufficient funds will be charged \$25.00. You will receive a monthly statement (payable upon receipt) showing you your balance after insurance has completed their processing and payment of the eligible benefits. I acknowledge that failure to pay an outstanding balance or contacting the office will result in interest and late fees added to my account, but we do offer 0% financing & monthly payment plans for all accounts if they are in good standing. If your balance becomes more than 90 days old, then interest of 12% and late fees of \$25.00 will be assessed monthly on overdue balances. We understand that medical bills are often expensive and thus we want to work with you to make sure it is affordable but can only happen if we have open lines of communication. If I am unable to pay in full at this time, I will make payment arrangements with NTAAA. Account balances that have not been paid within 120 days or are not on an approved payment plan will be turned over to a licensed collection agency.

**OTHER FEES:** Our fees for medical services are comparable to other similarly trained providers in the community and reflect the complexity of your specific needs, the provider time dedicated to your care, the specialized nature of the provider's education and training and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time. **Missed Appointments:** Please understand that when you reserve an appointment with one of our providers, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. To assist all our patients with appropriate access to our providers, we may charge a self-pay fee for repeated appointments that are cancelled with less than 24 hours' notice. **Medical Forms:** The completion of disability forms, attending provider statements and other supplemental insurance forms all require provider and staff time to complete. Accordingly, a \$25.00 fee may be charged to complete these forms.

**I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for providing correct insurance information, and payment of any services not covered or approved by the insurance carrier.**

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

**IF A MINOR, PLEASE COMPLETE BELOW:** Custodial Guardian (where the child lives) – Parent or legal guardian:

Relationship: \_\_\_\_\_ Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Secondary Guardian (who is legally authorized individual to bring in minor for treatment) – Must be at least 18 years of age

Relationship: \_\_\_\_\_ Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

# NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

## PATIENT PORTAL AUTHORIZATION FORM

The Patient Portal is designed to improve provider and patient communication at North Texas Allergy & Asthma Associates (NTAAA). The patient portal is not designed to replace the face-to-face encounters, but rather to supplement those encounters. Once you are established as a patient and have provided us with your secure email you will be assigned a username and password. After your patient portal registration has been completed, you will be allowed the following:

- Update your contact information
- Request your own appointments
- Communication of laboratory results
- Review your medical summary, medication list, treatment history, office visits & pay your outstanding balance.
- Receive reminders through your email

The following will **NOT** be accepted through the Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when you are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill for medication not currently being prescribed by a NTAAA Provider

**Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency, you should call 911. If you have an urgent request, please contact the office via telephone.**

### Patient Portal guidelines:

- If you forget your password, you may request another one through Patient Portal by clicking on the "Forgot Password" link.
- After you are finished accessing the Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
- Avoid using a public computer to access the Patient Portal.
- The Patient Portal is provided as a courtesy service for our patients. There is **no fee** to use the portal.
- We encourage you to use the portal at any time; however, messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your provider is out of the office, your request may be held until your provider returns to the office. If you have not heard from us within 3 business days, please call our office to check the status of your request.
- We reserve the right to suspend or terminate access to the patient portal at any time and for any reason.
- If your message contains too many complex issues we will ask you to come in for an appointment
- All information on the portal is considered part of your medical record.
- Patient or legal guardian must be at least 18 years of age to be eligible to access the Patient Portal.

**How the Patient Portal Security Works:** A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

**Protecting Your Private Health Information and Risks:** This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on the secure message reaching the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to the message. Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.** You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

**Patient Acknowledgement and Agreement:** I (we) acknowledge that I (we) have read and fully understand this consent form and the policies & guidelines regarding the Patient Portal. I (we) understand the risks associated with online communications between my provider and me (us), and consent to the conditions outlined herein. In addition, I (we) agree to follow the instructions set forth herein, including the policies and guidelines set forth in the log in screen, as well as any other instructions that my provider may impose to communicate with patients via online communications. I (we) understand and agree with the information that I (we) have been provided.

Email Address: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ If minor, Name of Legal Guardian \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Signature of Legal Guardian: \_\_\_\_\_



# NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Locations throughout Dallas – Specializing in personalized care since 1927

Main: (214) 369-1901 ~ Fax: (214) 369-1905

Web: www.texasallergy.com

## GENERAL DISCLOSURE AND INFORMED CONSENT

**TO THE PATIENT:** You have the right, as a patient, parent, or legal guardian, to be informed about the condition and the recommended medical or diagnostic procedure to be used, so that you may make the decision whether to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to the treatment or procedures recommended to you.

I (we) am (are) of sound mental and physical condition, and I (we) am (are) able to give informed consent. I (we) acknowledge that I (we) am (are) fully aware of the care, treatment, and/or services that I (we) am (are) going to receive that is subject to this form. I (we) acknowledge that this form is a general form for being seen as a patient of NTAAA.

I (we) voluntarily consent to receive medical and health care services provided by North Texas Allergy & Asthma Associates (“NTAAA”) health care providers, advanced practice clinicians (PA/NPs), employees, assistants, and staff, as they may deem necessary. I also understand that persons in professional training programs may be among the persons who provide care to me.

I (we) understand that my provider may discover other or different conditions, which may require additional or different procedures than those planned. I (we) realize that common to medical and/or diagnostic procedures is the potential for infection, bleeding, fainting, allergic reactions, and in very rare instances, even death. I (we) understand that if my provider decides to perform a procedure in their professional judgment, a specific consent form for that procedure will need to be completed. Just as there may be risks and hazards in continuing my present condition, with or without treatment or procedure(s), there are also risks and hazards related to the performance of the medical and/or diagnostic procedures, which may be planned for me.

I consent to and authorize procedures and treatment at NTAAA locations. I understand that in connection with my treatment, photos or videos may be taken.

I (we) understand that no warranty or guarantee has been made to me as to the result of any procedure and treatment or cure of any condition. I understand that all supplies, medical devices and other goods provided or billed to me by NTAAA are provided by NTAAA on an “as is” basis, and NTAAA disclaims any expressed or implied warranties with respect to them.

I acknowledge that NTAAA may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

**I understand that this General Disclosure and Informed Consent will be valid and remain in effect as long as I attend or receive services from NTAAA, unless revoked by me in writing. I (we) am (are) confident that I (we) have received adequate information to grant this general disclosure and informed consent for treatment.**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_

IF A MINOR, PLEASE COMPLETE THIS SECTION (Parent or legal guardian):

Relationship: \_\_\_\_\_ Name: \_\_\_\_\_ Signature: \_\_\_\_\_

# NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Name:

### PMH - Physicians

PCP: \_\_\_\_\_  
 Specialist: \_\_\_\_\_  
 Specialist: \_\_\_\_\_  
 Specialist: \_\_\_\_\_

### PMH - Current Medical Diagnosis

Heart attack  
 High blood pressure  
 Diabetes  
 Kidney disease  
 Liver disease  
 Stroke  
 COPD  
 Sleep Apnea  
 Acid reflux disease (GERD)  
 Thyroid disease  
 Auto-Immune disease: \_\_\_\_\_  
 Rheumatoid Arthritis  
 Osteoarthritis (DJD)  
 Gout  
 Irritable Bowel Syndrome (IBS)  
 Inflammatory Bowel Disease (IBD)  
 Migraines  
 Seizure disorder  
 Anemia  
 Blood clots  
 Glaucoma  
 Cataracts  
 Anxiety  
 Depression  
 Cancer: List Types \_\_\_\_\_  
 \_\_\_\_\_  
 Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### PMH - Surgical History

Eye surgery  
 Sinus surgery  
 Removal of Adenoids  
 Removal of Tonsils  
 Removal of Gall Bladder  
 Removal of Appendix  
 Other: \_\_\_\_\_  
 \_\_\_\_\_

### ROS - General

Fever  
 Chills  
 Weight Gain/Loss

### For Women Only

Are you currently pregnant  
 Planning pregnancy soon

(Please be sure to complete reverse)

### ROS - Ears, Nose, and Throat

Middle ear infections  
 Ear canal infections  
 Ear tubes  
 Hearing loss  
 Dizzy spells  
 Snoring  
 Hoarseness  
 Frequent sore throats  
 Other: \_\_\_\_\_

### ROS - Eyes

Blurred vision  
 Double vision  
 Light sensitivity  
 Eye Pain

### ROS - Gastrointestinal

Nausea  
 Vomiting  
 Abdominal Pain  
 Diarrhea  
 Constipation  
 Jaundice  
 Painful swallowing  
 Food getting stuck (impaction)  
 Ulcer  
 Hiatal hernia

### ROS - Skin

Hives  
 Rash  
 Eczema  
 Other: \_\_\_\_\_  
 \_\_\_\_\_

### ROS - Heart

Heart murmur  
 Irregular pulse  
 Pacemaker

### ROS - Musculoskeletal

Joint pain  
 Joint stiffness  
 Osteoporosis

### ROS - Endocrine

Frequent thirst  
 Heat intolerance  
 Cold intolerance  
 Easily fatigued

### ROS - Psychiatric

Memory loss  
 Mood changes

Date:

### ROS - Neurological

Headaches  
 Lightheaded

### ROS - Lung & Chest

Pneumonia  
 Pleurisy  
 Chronic bronchitis

### ROS - Hematologic

Easily bruised or bleed  
 Swollen glands  
 Other: \_\_\_\_\_

### Social - Smoking History

Do you smoke? YES NO  
 If yes - what do you smoke:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How many years:  
 How many packs per day:  
 Any 2nd hand smoke? YES NO

### Social - Alcohol Use

Do you drink alcohol? YES NO  
 If yes - what kind:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How many times a day?

### Social - Illicit Drug Use

Any illegal drugs? YES NO  
 If yes - what kind:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How did you use?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

| Medications   |  | Family History   |        |        |             |            |         |               |
|---|--|--|--------|--------|-------------|------------|---------|---------------|
| Please list all medications including supplements and over the counter drugs you are taking. Be sure to indicate strength and how many times a day. If you have a list of medications, please provide it to a medical assistant and you can skip this list. |  |  | Mother | Father | Brother (s) | Sister (s) | Son (s) | Daughters (s) |
|   |  | Allergies  |        |        |             |            |         |               |
|   |  | Asthma   |        |        |             |            |         |               |
|   |  | Eczema   |        |        |             |            |         |               |
|   |  | Sinus Problems   |        |        |             |            |         |               |
|   |  | Hives  |        |        |             |            |         |               |
|   |  | Food Allergies   |        |        |             |            |         |               |
|   |  | Allergic reactions   |        |        |             |            |         |               |
|   |  | Immune issues  |        |        |             |            |         |               |
|   |  | List medical problems that occur in your family (familial disorders) |        |        |             |            |         |               |
| Drug Allergies:   |  |  |        |        |             |            |         |               |
|   |  |  |        |        |             |            |         |               |

| Environmental History        |                             |                                |
|------------------------------|-----------------------------|--------------------------------|
| Animal Exposure              |                             | Other                          |
| Do you have any pets? YES NO | Exposed to animals at work? | Are you sensitive to perfumes? |
| If Yes - # of cats:          | What kind?                  | What kind?                     |
| # of dogs:                   |                             |                                |
| # of birds:                  | Any other work exposures?   |                                |
| # of gerbils/guinea pigs:    |                             |                                |
| # of rabbits:                |                             |                                |
| # of horses:                 |                             |                                |

**Pediatric History (only complete if less than 16 years old)**

Pediatrician: \_\_\_\_\_ History by: \_\_\_\_\_

Current Living Situation: \_\_\_\_\_ Medical/Legal guardianship: \_\_\_\_\_

Grade level: Pre-K    Elementary School    Middle School    High School

Any early childhood deaths reported in the family: YES or NO    If yes, from what: \_\_\_\_\_

Pregnancy and Birth History:    Maternal health during pregnancy: \_\_\_\_\_

    Gestational age at delivery: \_\_\_\_\_    Labor & Delivery - Any fetal distress?: YES or NO

    Type of delivery: Normal Vaginal    Complicated Vaginal    Normal C-section    Complicated C-section

    Neonatal period complications: Low Apgar scores?: \_\_\_\_\_    Other problems: \_\_\_\_\_

Developmental History: Delayed milestones: YES or NO

    Problems in School: \_\_\_\_\_    Behavior issues: \_\_\_\_\_

Feeding History: Feeding: Breast Fed    Bottle Fed

    Formula: \_\_\_\_\_    Problems with Formula: \_\_\_\_\_

    Solids: Age when introduced: \_\_\_\_\_    Problems: \_\_\_\_\_

Immunizations: Up-to-Date: YES or NO    Not immunized to: \_\_\_\_\_

Problems with vaccines: \_\_\_\_\_