Allergy, Asthma & Immunology Center (AAIC), PLLC.
SRIVIDYA SRIDHARA, MD
SASHA ALVARADO, DO

623 W FM 544, Suite #104
Murphy, TX 75094
Phone: 972-521-3366
Fax: 972-422-5656

8080 Independence Parkway Suite #150
Plano, TX 75025
Phone: 972-521-3366
Fax: 972-422-5656

PATIENT INFORMATION

Date

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Date Of Birth: _____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____

Best Phone #: _____ **Alt Phone #:** _____

Work Phone #: _____ **Alt Phone #:** _____

Employer _____

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

FINANCIAL RESPONSIBILITY (Section II)

(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)

☐ **CHECK HERE IF "SELF"**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Date Of Birth: _____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____

Home Phone #: _____ **Cell Phone #:** _____

Relationship:
- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other (Specify)

EMERGENCY CONTACT

Contact Name: _____

Relationship: _____

Contact Phone #(s): _____

PHARMACY INFORMATION

Name Of Pharmacy:	Zip Code or Street Address:	Pharmacy Phone:	Pharmacy Fax:

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PRIMARY INSURANCE INFORMATION (GIVE CARD TO RECEPTIONIST UPON ARRIVAL)

Insurance Company: _____

Relationship to Insured _____

Phone # for Providers/Eligibility & Benefits: _____

Member Number: _____

Group Number: _____

SECONDARY INSURANCE INFORMATION (GIVE CARD TO RECEPTIONIST UPON ARRIVAL)

Insurance Company: _____

Phone # for Providers/Eligibility & Benefits: _____

Member Number: _____

Group Number: _____

HOW DID YOU HEAR ABOUT US?

☐ Referred by Physician - Physician's Name: _____

Phone: _____

Fax: _____

☐ Internet Website or Search Engine – Which site did you initially find us on? _____

☐ Newspaper/Magazine Article Or Ad – Which publication? _____

☐ Insurance Plan (Check here if you found us thru your insurance plan's website or in their provider directory.)

☐ Friend or Family Member: _____

☐ Other – Please describe: _____

OTHER PHYSICIANS

Physician Name:	Physician Phone:	Physician Fax:

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Privacy and Communications Consents

A. Telemedicine

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients located at different sites.

1. All federal and Texas state laws protecting the privacy and confidentiality of medical information also apply to telemedicine.
2. You will not be physically in the same room as the physician. Your consent will be obtained for anyone other than your physician present in the room.
3. Potential risks to using technology include interruptions, unauthorized access and technical difficulties.
4. You or the physician can discontinue the telemedicine visit and future telemedicine visits at any time. Withdrawal of your telemedicine consent will not affect future care or treatment.
5. Certain procedures such as allergy testing and pulmonary function testing cannot be performed via telemedicine. If any procedure is deemed necessary after the televisit, you will be scheduled separately for the procedures and billing for those is separate as per your insurance benefits.
6. Your physician may determine that telemedicine discussion is not adequate and may request an in-person visit to the office for more detailed examination and testing. If this occurs, you will only be charged for the in-office visit.
7. Your health care information may be shared with other individuals for scheduling and billing purposes.
    a. Your insurance carrier will have access to your medical records for quality review/audit.
    b. You will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to telemedicine visits.
    c. Health plan payment policies for telemedicine visits may be different from policies for in-person visits.
8. You will be required to pay the applicable co-pay before the visit occurs. AAIC staff will do their best to verify that your insurance covers telemedicine visits. However, if a telemedicine visit is deemed as not part of your insurance benefits, you will be responsible for the office cash-price fee of **$100.00.**

Your Responsibilities:

1. You must be physically within Texas (including offshore State waters) to be eligible for telemedicine.
2. You may not record any telemedicine session without written consent from AAIC. We will not record any telemedicine session without your written consent.
3. Inform us as soon as your session begins if there are any other surrounding people listening or watching the session. You give your consent for them to listen in on your medical care.
4. Notify us immediately if your equipment fails or you are unable to hear audio clearly.

Regarding telemedicine services, I am requesting the option below:

- ☐ **(Option 1) I want my insurance to be billed for Telemedicine visits and will pay the applicable copay or deductible before the consultation. However, if my insurance company does not pay for the visit, then I am responsible for the insurance contracted rate. If my insurance does pay, AAIC will refund any payments I made, less copays or deductibles.**

☐ (Option 2) I will pay the office cash-price fee of $100.00 and insurance will not be billed. I will not attempt nor request AAIC to file any claims at a later time to any insurance carrier for coverage of services rendered to me for this telemedicine visit.

☐ (Option 3) I decline the option for the Telemedicine visits.

I acknowledge that I have read and understand the AAIC telemedicine policy.

_____	_____
Signature	Patient Name
_____	_____
Date	Relationship to patient

B. Email communication consent

1. To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at staff@murphyplanoallergy.com.
2. Remember electronic message delivery may be delayed. Email is NOT appropriate for use in an emergency. Turnaround time for routine patient communications is 1-2 business days.
3. When emailing us, please include a subject line to help us process your message efficiently. In the body of your message, include the patient's name, date of birth, and return telephone number. Please acknowledge receipt of emails coming from our office (for example, by replying, "Received.")
4. Communications related to diagnosis and treatment will be filed in your medical record.
5. We are dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, be aware that your messages may be monitored. Even when emailing from home, consider whether access to your email is controlled. Also be aware that regardless of who your email is addressed to, multiple AAIC staff will have access to information you send.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that AAIC may send medical related correspondence to you via email, and that we may respond to your messages via email.

_____	_____
Signature	Patient Name
_____	_____
Date	Relationship to patient

C. Consent for text messaging reminders

1. AAIC or others acting on our behalf such as the electronic medical record vendor may send text messages including, but not limited to, appointment reminders and notifications about new patient portal messages.
2. You represent that you are the owner or authorized user of the mobile phone number identified below. You will notify us immediately if you are no longer the owner or authorized user of this mobile number.
3. You are solely responsible for any message and data charges associated with such text messages.

□ I agree to the above and consent to receive text messages at mobile number _____
□ I do not wish to receive text messages from AAIC.

D. Acknowledgment of Receipt of Notice of Privacy Practices

1. The notice of Privacy Practice is available on our website and as a hard copy upon request.
2. As part of your healthcare Allergy, Asthma & Immunology Center, PLLC (AAIC) originates and maintains health records describing your health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. This information is utilized to plan your care and treatment, to bill for services provided, 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 your express consent.
3. The Physician's Notice of Privacy Practices provides specific information and a complete description of how your personal health information may be used and disclosed.
4. You have the right to review the notice prior to signing this acknowledgement.
5. AAIC reserves the right to change the Notice of Privacy Practices. The revised Notice will be made available to you.

I acknowledge that I have been provided and have reviewed the Notice of Privacy Practices dated February 3rd, 2014.

_____ _____
Signature Patient Name

_____ _____
Date Relationship to patient

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Financial policy

A. Insurance and Payment Acknowledgement
   1. Non-insured patients: Payments for services rendered are due at the time of service. If you are unable to pay in full at the time of service, you may make payment arrangements with AAIC.
   2. Insured patients: You are responsible for providing us with correct insurance information. Allergy, Asthma & Immunology Center (AAIC) will file your insurance claim for you.
   3. Deductible and any out-of-pocket portions including co-pay and balance on your account are due at the time of service. You will be responsible for any outstanding balance that your insurance company does not cover on services rendered.
   4. The balance on your statement is due and payable when the statement is issued and is past due if not paid within 15 days. This is an agreement between Allergy, Asthma and Immunology Center, PLLC, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you are agreeing to be financially responsible for all services received.
   5. Failure to pay an outstanding balance may result in interest and late fees added to your account.
   6. If you do not make payment arrangements with AAIC, the outstanding balance will be sent to a collection agency. In this case, you will need to pay your unpaid balance plus collection costs.
   7. Waiver of confidentiality: 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 AAIC may become a matter of public record.
   8. Returned checks will incur a $30.00 fee. This fee, in addition to the amount of the returned check, will be due by cash, money order, certified check, or credit card within 15 days.

B. Missed Appointments: Please understand that when you reserve an appointment, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. If an appointment is not cancelled at least 24 hours in advance, you may be charged a $50 NO-SHOW fee. This will not be covered by your insurance company.

ASSIGNMENT OF BENEFITS: I hereby authorize the staff of AAIC to release any information required to process this claim and claims for any future treatment unless rescinded by me in writing. I authorize payment of medical benefits to AAIC for services performed. I also understand that any and all services (including any procedures and allergy extract) that are not covered by the insurance will be my responsibility.

I acknowledge that I have read and understand the AAIC financial policy including but not limited to insurance and collection practices.

_____ _____

Signature Patient Name

_____ _____

Date Relationship to patient

Patient name: _____ **DOB:** _____

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information, then sign and date form.

Patient Name:	Date of Birth:	Relationship to Patient:

MEDICAL RECORD AND INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION RELEASE: I authorize AAIC to release my medical information and/or individually identifiable health information to me, my 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 further authorize AAIC to release such information to physicians, hospital, or healthcare providers needing such information to treat me or to review my treatment. I 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 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.

Name:	Telephone:	Relationship:
Name:	Telephone:	Relationship:
Name:	Telephone	Relationship:

Information to be disclosed:
I authorize AAIC physician and staff to disclose or provide the following types of protected health information to the person(s) or entity identified above:

□ All information about specialist care received □ All diagnostic test results □ Lab results only
□ Billing statements of charges for care only □ Other (specify):_____

Authorization for disclosure of PHI via alternative means:

I authorize AAIC physician and staff to disclose my PHI in the following manner. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address, e-mail, or number, indicated by me, is subject to the redisclouser statement within this authorization.

I understand that the privacy risks of mail, phone calls, and email. I hereby authorize a representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as reminders, laboratory results, and office notifications. I understand that I have the right to rescind this authorization at any time by notifying AAIC in writing.

Check the box that applies.
□ Home Phone: _____ □ Cell Phone_____
□ E-mail:_____ □ US Mail

□ Leave detailed messages on answering machine/voicemail □ Leave no message
□ Leave messages with only call-back number (includes staff members name and doctor's office on my answering machine /voicemail)

Expiration of Disclosure:
This authorization will expire 1 year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time by notifying the privacy officer in writing. Please specify expiration date if less than 1 year_____

Re disclosure: AAIC has no control over the person(s) or entity you have listed to receive your protected health information. Therefore, protected health information disclosed under this authorization will no longer be protected by the requirements of the privacy rule and will no longer be the responsibility of the practice.
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 this document.

_____

Patient / Guardian Signature **Date of Signature**