Miguel P. Wolbert, M.D.
5000 Briarwood Avenue
Midland, Texas 79707
Office (432) 682.5385 Fax (432) 682.1265

Welcome to West Texas Allergy. We are glad you have chosen our office and have decided to trust us with your care. In a sincere effort to maintain patient satisfaction while honoring the need to maximize effectiveness and efficiency of our work processes, we have implemented procedures which we hope will let us provide you with the best quality medical care we can. We firmly believe, and our experience has shown it to be true, that patients who are consistent in keeping their appointments have fewer episodes of acute illness, difficulty with unstable chronic illnesses and generally continue to enjoy better health overall.

For the benefit of you, our patient, we are contracted with several insurance carriers as a provider. You will want to check your benefits booklet or with the benefits department of your employer to verify if our physician(s) are listed as providers within your network. As part of our contract with the insurance companies we are legally required to collect any co-pays or deductibles from you at the time of service. **We do ask that you be prepared to pay your co-pay and at least $500 of your deductible (unless all of the deductible has been met prior to your appointment) at the time of check in.** Failure on our part to collect these monies can result in cancellation of our provider contract.

Patients who **do not** have insurance coverage will be expected to pay at the time of service.
A $100 deposit will be collected before seeing the physician on new patient visits. Your balance will be reconciled at the time of checkout. We do offer a 20% discount for same day payment of services. For your convenience we accept cash, check, MasterCard, Visa and American Express.

It is our desire to have a mutually respectful relationship with our patients. As part of the relationship we expect our patients to maintain a good credit rating with our office. Failure to pay for medical services delivered in good faith will cause a patient's account to be turned over to an outside agency for collection. Should collection proceedings be required to collect an outstanding debt you will be responsible for all additional expenses incurred to collect the debt including the collection agency fees and any associated court costs. Should this become necessary West Texas Allergy retains the right to discharged you from the practice.

We will call you 48 hours in advance of your appointment. We do understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we do request you extend us the courtesy of a 24-hour notice.

Again, thank you for choosing West Texas Allergy. We look forward to working with you!

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Date Patient Called: _____

Appointment Date & Time:
_____
_____

Patient Information

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____
Last First Middle Initial

Soc. Sec. #: _____Birthdate: _____

Home Address: _____

☐Male ☐Female

Email Address: _____

Patient Employed by: _____ Occupation: _____

Person Responsible for Account (if different from person above):

Name: _____ Social Sec. #: _____

Relationship to Patient_____ Birthdate: _____ Phone: _____

Address (if different from above): _____

Soc. Sec # of insured: _____ Employed by: _____

Insurance Company: _____ Insurance Address: _____

Group No. _____ Subscriber ID: _____

Is patient covered by additional insurance: ☐Yes ☐No

Secondary Insurance Subscriber Name: _____

Relationship to Patient: _____ Birthdate: _____

Soc. Sec. #_____

Address (if different from above): _____

Phone: _____ Employed by: _____

Insurance Company: _____ Insurance Address: _____

Group No. _____ Subscriber ID: _____

Over for more.

West Texas Allergy

Patient Information Continued

Name: _____
Last First Middle Initial

Soc. Sec. #:_____Birthdate: _____

Did a physician refer you to see us? ☐Yes ☐No

If yes, Doctor's Name: _____

If a physician did not refer you, how did you hear about us? _____

Primary Care Physician's Name: _____

Reason for Visit: _____

How long have you had this condition? _____

Describe the most distressing symptoms you feel are caused by your allergy:

_____

_____

_____

List all medications you have tried in the past for allergy (all oral, topical and nasal sprays) and the response you had to each:

_____ _____

_____ _____

_____ _____

Known Allergies to Medications (List names and symptoms you had):

_____

_____

All Current Medications (include allergy medications):

_____

_____

_____

_____

_____

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Patient Instructions for Skin Testing

Based upon the findings of Dr. Wolbert during your appointment, it may be determined that you will need allergy skin testing. Should that be the case, we ask that you read the information below and make sure not to take any of the listed medications at least three days prior to your appointment as we will do the skin testing the same day as your appointment. **Please allow extra time for your initial appointment in the event testing is necessary.**

Aeroallergen skin testing is done using the prick and intradermal methods. These methods are used by board-certified allergists and are accepted as the standard method for the diagnosis of allergic disease. Skin testing is not painful and is the most cost-effective method of allergy testing available. Allergy testing can be safely performed at any age.

Depending on the history of your allergy symptoms you will be tested to common inhalant allergens including pollens, pet dander, molds and dust mites. Occasionally, skin tests to common food allergens will also be included. Should your skin prick tests be negative, we might also perform intradermal skin tests to be sure that important allergen sensitivities are not missed. However, intradermal testing is not done on young children.

IMPORTANT: Certain medications must be stopped prior to allergy skin testing.
Please do not take any medicines that contain antihistamines for at <u>least 3 days prior</u> to your appointment.

Common antihistamines include:

- Clarinex, Claritin, Allegra, Zyrtec, Astelin, Actifed, Atarax, Benadryl, Dimetapp, Dymista, Xyzal, Patanase, Astepro, Trinalin, Periactic, Phenergan, Triaminic
- Decongestant/antihistamine combination medications
- Any over-the-counter allergy medicines or cold & cough remedies
- Any over-the-counter sleep aids − they usually contain sedating antihistamines
- Some medications for dizziness and anti-depressants (tricyclic antidepressants) can also contain antihistamines.

You should continue to take as prescribed the following medications:

- Antibiotics
- All asthma medications
- Oral steroid/prednisone
- Prescription nose sprays, with the exception of Astelin, Astepro, Patanase, Dymista
- Decongestants that are not combined with an antihistamine
- All of your other non-allergy medications

Should you have a question about a specific medication, please feel free to call us at 432.682.5385.

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RELEASE OF INFORMATION: I hereby authorize the physician and/or supplier to release any information required to process this claim and claims for any future treatment unless rescinded by me in writing.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to West Texas Allergy which includes: Dr. Wolbert, M.D. and any Mid-Level Providers *(Physician Assistant, Nurse Practitioner)* for services performed. **I also understand that any and all services (including allergy extract) that are not covered by the insurance will by my responsibility.**

Date: _____ Signature: _____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made on my behalf to West Texas Allergy for any services furnished by the physician, physician assistant and/or nurse practitioner. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “the other health insurance” is indicated in box 9 of the HCFA-1500 form or elsewhere on the approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determined of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services.

Date: _____ Signature: _____

Over for more.

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Medical Information Authorization

Date: _____

I hereby authorize West Texas Allergy to release all medical information of *(write in name of patient)* _____ _____ with the social security number of _____ and date of birth of _____ and residing at *(write in patient address)* _____ _____to the friends and family listed below.

Name: _____ Relationship to patient: _____ Phone Number(s):_____
Name: _____ Relationship to patient: _____ Phone Number(s):_____
Name: _____ Relationship to patient: _____ Phone Number(s):_____
Name: _____ Relationship to patient: _____ Phone Number(s):_____
Name: _____ Relationship to patient: _____ Phone Number(s):_____

I understand that this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the above information to the extent indicated and authorized herein.

Date: _____ Signed: _____ *(by patient or representative)*

If not patient – my relationship to the patient is: _____.

Witness: _____ Date: _____

West Texas Allergy

REQUEST FOR CONFIDENTIAL COMMUNICATIONS
&
ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

Name of Patient: _____
(please print)

Date of Birth: _____

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I request that all communications to me (by telephone, mail, electronic mail or otherwise) by West Texas Allery and staff are handled as follows:

• For WRITTEN Communication Address to:

_____

_____

• For ORAL Communication Call:

Home: _____ May we leave a message? ☐ Yes ☐ No

Work: _____ May we leave a message? ☐ Yes ☐ No

Cell: _____ May we leave a message? ☐ Yes ☐ No

• Electronic Mail Communication to E-mail Address: _____

If the address above is not your home address OR is not a street address, please provide us with a street address for purposes of ensuring payment:

_____

_____

• I wish to place the following restrictions on disclosure of my health information:

_____

Patient (Guardian) Signature: _____Date: _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

[This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.]

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.

If you have any questions about this Notice please contact the office manager.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national

security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer/Office Manager at 432.682.5385 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.