Southwest Asthma & Allergy Associates

(Please Print) (Letra de Molde)

Date: Fecha:	Primary Care Physician: Medico de atencion primaria:	Referring Physician: Medico referente:

PATIENT INFORMATION/INFORMACION DEL PACIENTE

Patient's last name: Apellido del paciente:	First: Nombre:	Middle: 2ndo nombre:	☐ Mr./Sr. ☐ Mrs./Sra.	☐ Miss/Señorita ☐ Ms.

Street address: Dirección:	City: Cuidad:	State: Estado:	Zip Code: Codigo postal:

Home Phone: Tel. de casa:	Cell pone: Celular:	Email: Correo Electrónico:

Date of Birth: Fecha de nacimiento:	Age: Edad:	Sex: ☐ M ☐ F	Marital status/Estado Civil: ☐ Single/Soltero(a) ☐ Mar/Casado(a) ☐ Div/Divorciado(a)	Social Security: Seguro social:

Employer: Empleador:	Employer phone: Tel. de trabajo:	Ethnicity: Etnia:

Chose clinic because/referred to by (Please check one box): Como se entero de nosotros? (favor de marcar una casilla):	☐ Dr./Doctor(a)	☐ Insurance plan/Seguro medico	☐ Hospital

☐ Family/Familia	☐ Friend/Amigo(a)	☐ Close to home or work/Cerca de casa/trabajo	☐ Other/Otro

Other family members seen here:
Otro miembro de la familia visto aquí:

If the above-named patient is a minor, may we ask the name of each parent? ¿Si el paciente mencionado anteriormente es menor de edad, podemos preguntar el nombre de cada padre?	Mother: Madre:	Father: Padre:

INSURANCE INFORMATION/INFORMACION DEL SEGURO

(Please give your insurance card to the receptionist. Statements and bills will be addressed to responsible party.)
Por favor entregue su tarjeta de seguro a la recepcionista. Estados de cuenta y facturas serán dirigidas al responsable.

Person responsable for Bill: Persona responsable de la factura:	Date of Birth: Fecha de nacimiento:	Address (if different): Direccion (si es diferente):	Home phone: Telefono de casa:

Social Security: Seguro social:	Driver's License no.: Licencia de conducir:	Issuing state: Estado emisor:

Subscriber name: Nombre del suscriptor:	Birth date of insurance subdcriber: Fecha de Nacimiento del suscriptor:	Sex: ☐ M ☐ F

Patient's relationship to insured: Relacion del paciente con el asegurado:	☐ Self/Yo mismo(a)	☐ Spouse/Esposo(a)	☐ Child/Menor	☐ Other/Otro

Name of Primary insurance: Nombre del Seguro primario:	Subscriber no.: Numero de suscriptor:	Group name: Nombre del grupo:	Group no.: Numero de grupo:

Employer: Empleador:	Employer address: Direccion de trabajo:	Employer phone no.: Telefono del trabajo:

Name of Secondary Insurance (If applicable): Nombre del sguro secundario (si aplica):	Subscriber name: Nombre del suscriptor:	Date of Birth: Fecha de Nacimiento:	Subscriber no.: Numero de suscriptor:

Patient relationship to subscriber: Relacion del paciente con el suscriptor:	☐ Self/ Yo mismo(a)	☐ Spouse/Esposo(a)	☐ Child/Menor	☐ Other/Otro

IN CASE OF EMERGENCY/EN CASO DE EMERGENCIA

Emergency contact: Contacto de emergencia:	Relationship to patient: Parentesco con el paciente:	Cell phone: Celular:	Home phone: Tel. de Casa:	Work pone: Tel. del Trabajo:

ADDITIONAL INFORMATION/INFORMACION ADICIONAL

Pharmacy Name: Farmacia:	Pharmacy phone no.: Tel. de Farmacia:	Pharmacy fax no.: Fax de Farmacia:

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PHYSICIANS CERTIFIED BY THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

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"Caring for Children and Adults with Asthma and Allergies"

SWAAA FINANCIAL POLICY

Thank you for allowing Southwest Asthma & Allergy Associates to participate in your healthcare. Please read the following and let us know if you have any questions.

- We will file your primary and secondary insurances as a courtesy.
- It is your responsibility to provide us with accurate updated insurance information and to inform us of any changes in your coverage as they occur.
- You are responsible for all copays, coinsurances, deductibles, and non-covered services.
- Completing disability forms, FMLA forms and other requested supplemental insurance forms requires prepayment of $25.00.

I hereby authorize any licensed physician, practitioner, hospital, clinic or other medical facility or it's representatives to release any and all information with respect to any illness or injury, medical history, consultation, prescription(s) or treatment and copies of medical records to: The physicians of Southwest Asthma & Allergy Associates. I also authorize Southwest Asthma & Allergy Associates, it's physician's and providers to release medical records to the insurance company responsible for my health coverage should it become necessary for payment of services provided.

_____ _____

Patient /Guardian Name (please print) Date

- I hereby assign benefits and authorize payment to go directly to Southwest Asthma & Allergy Associates for any medical services provided but not to exceed the reasonable and customary charges for these services.

- I understand that I am financially responsible to the physician for all charges not covered by this agreement. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

_____ _____

Patient / Guardian-Responsible Party Date

Print Patient Name_____ Account #_____

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NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer-Dr. Juan Zambrano.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

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This notice is effective as of April 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from this office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Southwest Asthma & Allergy Associates
Juan Zambrano, M.D.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

Southwest Asthma & Allergy Associates

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____