SWAAA.com
Southwest Asthma & Allergy Associates (Please Print) (Letra De Molde)

Date (Fecha):	Primary Care Doctor (Medico de atencion primaria):	Referring Doctor (Medico referente):

PATIENT INFORMATION (INFORMACION DEL PACIENTE)

Last Name (Apellido del paciente):	First name (Nombre):	Middle (2ndo nombre):

Street Address (Direccíon):	City (Ciudad):	State (Estado):	Zip Code (Codigo postal):

Cell Phone Number (Celular):	Email (Correo Electronico)	Social Security # (Seguro Social):

Date of Birth (Fecha de Nacimiento):	Age (Edad):	Marital status (Estado civil): ◯ Single/Soltero(a) ◯ Mar/Casado(a) ◯ Div/Divorciado(a)	Ethnicity (Etnicidad):

Referred to clinic by (Como se entero de mosotros?):

◯ Doctor/Medico(a) ◯ Insurance/Seguro medico ◯ Hospital ◯ Family/Familia ◯ Friend/Amigo(a) ◯ Other/Otro

If patient is a minor, please list parents name (Si el paciente es menor de edad, indique el nombre de los padres)	Mother (Madre):	Father (Padre):

INSURANCE INFORMATION (INFORMACION DEL SEGURO)

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

Insurance Name (Nombre de aseguranza)	Identification # (Numero de identificacion)	Group # (Numero de grupo)

Person responsible for bill (Persona responsable de la factura):	Date of birth (Fecha de Nacimiento):	Cell Phone (Celular):

IN CASE OF EMERGENCY (EN CASO DE EMERGENCIA)

Emergency contact (Contacto de emergencia):	Relationship to patient (Relacion al paciente):	Cell phone (Celular):

PHARMACY (FARMACIA):

Pharmacy name (Farmacia):	Pharmacy address or phone # (Direccion de Farmacia o numero):

HIPAA/ MEDICAL RELEASE FORM

◯ I authorize the release of information including my (my child's) diagnosis, records, examination rendered to me and claim 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.

CONSENT TO TREAT MINOR PATIENT WIHTOUT PARENT/ LEGAL GUARDIAN PRESENT

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I preauthorize Southwest Asthma & Allergy Associates and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. Routine medical care and interventions that may include but are not limited to medical evaluation, physical exam, injections, lab work, allergy testing, allergy injections, spirometry and nebulizer treatments. I am aware that the adult presenting the child will be responsible for payment of the patient portion at the time of service.
I have read, understand and give my consent as stipulated above. My signature means that I have read this form and/ or have had it read to me in the language I can understand.

Patient, Parent or Legal guardian (Please Print): _____ Date: _____

Patient, Parent or Legal guardian Signature: _____ Cell Phone: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.
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 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 healthcare operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more healthcare providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collections and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations** include the business aspects of running our practices, 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, 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 by alternative means or locations.
- The right to inspect and copy your protected health information.
- The right to receive 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 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 new notice provisions effective for all protected health information that we maintain. We will post or 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 a 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 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 my or my child(s) treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to 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 Privacy 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 healthcare 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 _____

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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 claims with the primary and secondary insurance 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, deductibles, coinsurances and non-covered services.
- Completed disability forms, FMLA forms and other requested supplemental insurance forms require prepayment of $50 or more.

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

_____ _____

Patient, Parent or Legal Guardian (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 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 TIMES SERVICES ARE RENDERED.

_____ _____

Patient, Parent or Legal Guardian (please sign) Date

Print patient name: _____ Account# _____