



Patient Registration Form

**Allergy, Asthma, and Immunology of
North Texas, PA**

Patient Information (for the individual being seen)

Last Name	First Name	Middle Name
Street	City, State, Zip	Sex _ Male _ Female
Date of Birth	Social Security	e-Mail Address
Home/Evening Phone	Business/Day Phone	Mobile/Other Phone
Occupation	If Student, _ Full-time _ Part-time	If Employed, _ Full-time _ Part-time
Employer/Other Contact	Phone	Address
Emergency Contact	Phone	Address
Married? _ Single _ Married _ Separated _ Divorced _ Widowed		_ Visit Related to Injury or Other Special Circumstances
Primary Care Physician to Whom Report Should be Sent	If Referred, Referring Physician to Whom Report Should be Sent	If not Referred, How Did You Hear about Us?

For the following sections, indicate "SAME" if guarantor and the insured patient are the same individual.

Primary (Guarantor) Insurance Information

Last Name	First Name	Middle Name
Street	City, State, Zip	Sex _ Male _ Female
Date of Birth	Social Security	e-Mail Address
Home/Evening Phone	Business/Day Phone	Mobile/Other Phone
Relation to Insured	Name of Employer Sponsoring Plan	Name of Insurance Company
Insurance Address	Insurance City, State, Zip	Insurance Phone
Insured Identification Number	Group Number	Effective Date

Secondary Insurance Information (if applicable)

Last Name	First Name	Middle Name
Street	City, State, Zip	Sex _ Male _ Female
Date of Birth	Social Security	e-Mail Address
Home/Evening Phone	Business/Day Phone	Mobile/Other Phone
Relation to Insured	Name of Employer Sponsoring Plan	Name of Insurance Company
Insurance Address	Insurance City, State, Zip	Insurance Phone
Insured Identification Number	Group Number	Effective Date

Consent to be Treated and for Payment

I have listed all health insurance plans from which I may receive benefit(s). I hereby authorize payment of medical benefits billed to my insurance to Allergy, Asthma, and Immunology of North Texas, PA (the "office"). I hereby accept responsibility for payment for any services provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the office does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I authorize the use or disclosure or both of health information that may specifically or be able reasonably to identify me for the sole purpose of carrying out treatment, payment, and health care operations. I understand that, while this consent is voluntary, if I refuse to sign this consent the office may decline to treat me.

I have been informed that the office has prepared a "Notice of Privacy Practices" that fully describes the use and disclosure that can be made of my individually identifiable health information for treatment, payment, and other routine health care operations. I understand that I have the right to review this HIPAA form prior to signing this consent. I may also revoke this consent at any time by notifying the Allergy office in writing, but if I revoke the consent such revocation will not affect any actions that the office took before receiving my revocation. The office has reserved the right to alter this privacy policy, and I understand that I can obtain such changes upon request. I have the right to request that the office restrict how my individually identifiable health information is used or disclosed to carry out health care operations. The office is not obligated to agree to such restrictions but once such restrictions are in place must then adhere to such restrictions.

NOTICE CONCERNING COMPLAINTS: Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas State Board of Medical Examiners, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information, please visit the website at www.tsbme.state.tx.us.

AVISO SOBRE LAS QUEJAS: Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de medicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas: Texas State Board of Medical Examiners, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018. Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353. Para obtener más información, visite el sitio web en www.tsbme.state.tx.us.

Thank you for completing this registration form.

Signature of Patient or Authorized Representative

Date

Name of Patient or Authorized Personal Representative

Description of Authorized Representative's Authority