Follow Up - Personal Information Sheet

Location: _____ Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

1. Primary Email of Correspondence: _____ **2.** Best Phone number to contact you: _____

3. Primary Care Physician: First name: _____ Last: _____ City: _____

4. Briefly describe the reason for your visit with our office: _____

_____

_____

5. Please list any and all Current **Prescription medications** that you take regularly or as needed for any reason- please indicate drug name, dose and dosing instruction: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

E. _____ **F.** _____

6. Please list any and all Current **Over the counter (OTC) medications** that you take regularly or as needed for any reason- please indicate drug name, dose and dosing instruction: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

E. _____ **F.** _____

7. Have you had anything new happen to your health since our last visit? ☐ Yes ☐ No

If Yes, please indicate the nature of the issue/issues:

A. _____ **B.** _____

C. _____ **D.** _____

8. Have you had any new surgeries since your last visit with us? ☐ Yes ☐ No

If yes, Please list the type of surgery, date, and surgeons's first, last name:

A. _____ **B.** _____

C. _____ **D.** _____

9. Immunization History-

A. Have you received this year's annual flu shot? ☐ Yes ☐ No ☐ Unknown If yes- when: _____

B. Have you ever received the Pneumonia shot Pneumovax? ☐ Yes ☐ No ☐ Unknown If yes- when: _____

C. Have you ever received the Pneumonia shot Prevnar 13? ☐ Yes ☐ No ☐ Unknown If yes- when: _____

10. Food Allergy- Please list any **food** allergy/intolerance and the specific symptoms experienced: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

11. Drug Allergy- Please list any **drug** allergy/intolerance and the specific symptoms experienced: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

12. Chemical Allergy- Please list any **chemical** allergy/intolerance and the specific symptoms experienced: ☐ None

A. _____ **B.** _____

C. _____ **D.** _____

13. Insect Allergy- Please list any **insect** allergy/intolerance and the specific symptoms experienced: ☐ None

A. _____ **B.** _____

14. Social History- Please answer the following questions regarding the patient's social status:

Have you had anything change in your social status since our last visit (change in job/ change in smoking status / change in living environment)? ☐ Yes ☐ No

If Yes, please list the change(s):

A. _____ **B.** _____

C. _____ **D.** _____

15. Are you routinely exposed to animals/pets? ☐ Yes ☐ No If yes, please list the type of animal/pet:

_____

16. Any other information you would like to share about your upcoming visit:

_____

_____

Consent: The above information is correct to the best of my ability and accurately reflects my/the patient's current state of health. Please sign below if you agree to this statement.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date completed/updated: _____

Southwest Allergy & Asthma Center

John Van Wagoner, MD, PA

CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health Information (PHI) to carry out treatment, payment activities, and healthcare operations (TPO).

Notice of Privacy Practices: This office will not disclose your PHI (name, address, phone number(s), social security number, date of birth, etc.) outside of the TPO without your specific authorization and consent. This office complies with HIPAA and all federal and state laws regarding the privacy of your information. The Notice of Privacy Practices is available on our website under Education. A printed copy is also available upon request.

You may refuse to sign this authorization.

Acknowledged and agreed to by:

PATIENT/GUARDIAN SIGNATURE	PATIENT NAME	PATIENT DOB

DATE COMPLETED/UPDATED

OPTIONAL: Disclosure of Protected Health Information

I understand that any and all medical care that I receive at Southwest Allergy & Asthma Center will be treated with the utmost confidentiality. To facilitate my medical care, I hereby authorize Southwest Allergy & Asthma Center to disclose PHI regarding my treatment and medical condition to the following individuals:

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

PATIENT FINANCIAL ADVISORY

NON-COVERED SERVICES

_____(initials) I understand Southwest Allergy and Asthma Center (SWAAC)'s contractual agreement with health care service plans relates only to items and services which are deemed "covered" by the individual health plan. Consequently, I accept full financial responsibility and agree to pay out-of-pocket for all items or services which are deemed "non-covered" by the individual health plan.

HMO REFERRALS

_____(initials) I understand that if my insurance company has designated a primary care physician (PCP), I am required to have prior authorization from my PCP prior to my office visit. If the authorization is not provided, whether by the Guarantor or through the insurance carrier, the Guarantor will be asked to either reschedule the appointment or pay for the visit out-of-pocket at the time of service.

SELF-PAY ACCOUNTS

_____(initials) Self-pay accounts are those (1) with no available health insurance coverage at the time of service or (2) are covered by an insurance carrier with which SWAAC does not participate. I agree to be individually responsible to pay the full charges at the time of service if I have a self pay account.

CHANGES TO COVERAGE

_____(initials) I understand that it is my responsibility to advise SWAAC of any changes with my insurance carrier, to confirm the practice's participation, and my eligibility prior to each visit. I agree to pay the full charges of all services rendered by SWAAC if services are deemed "non-covered."

SERVICES RENDERED

_____(initials) I agree that in return for services provided to the patient by SWAAC, the account balance will be paid at the time service is rendered or I will make appropriate financial arrangements satisfactory to SWAAC for payment. If co-payments, deductibles or co-insurance amounts are designated by a contractual agreement to an insurance provider or health plan, I agree to pay these amounts to SWAAC. I understand and agree that if my account is delinquent, my account may be referred to a third-party agency for collections and fees may apply if such services are utilized. If extenuating circumstances should prevent me from providing payment, I may discuss the matter with a Treatment Coordinator.

- As a courtesy, SWAAC files claims to your insurance provider. If you are covered by insurance, it is your responsibility to understand the provisions under which you are covered.
- Missed or cancelled appointments with less than a 24 hour notice will be subject to a $25 no-show fee. Excessive No-Shows will result in a non-refundable deposit prior to scheduling.
- A minimum fee of $25 may be assessed to release medical records.
- In the event that a guardian shares custody of a patient, the guardian present at the time of service is responsible for payment in full at that time. If you have a court order requiring treatment costs to be shared, it is the responsibility of the guardians to make appropriate arrangements prior to treatment.
- All returned checks will be assessed a $25 fee.

My signature below indicates I understand and agree to pay in full any balance unpaid by my insurance provider.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
*Legal Representative's Printed Name	Legal Representative's Signature	Date

_____

If representative, specify relationship to patient

SWAAC
SOUTHWEST ALLERGY & ASTHMA CENTER

Confidential Voicemail Authorization

- Occasionally, it may become necessary to contact our patient(s) by telephone. In the event you are not available by phone, we will leave detailed voicemail messages regarding your/your child's treatment. By providing your telephone number(s), you hereby grant SWAAC permission to leave detailed voicemail messages regarding your/your child's treatment.

- o **My cell phone:** _____
- o **My Home phone:** _____
- o **Family Member** _____
- o **Other (name)**: _____

Phone Number: _____ **Phone Number:** _____

- o I do not wish to receive voicemail messages regarding my/my child's treatment.

Text/E-Mail Messaging Authorization

- To better serve you, we utilize text and/or email messaging for appointment reminders and important announcements. By providing your mobile number(s) and email address, you hereby grant SWAAC permission to contact you regarding appointment reminders and important announcements.

E-Mail:_____**Cell:**_____

- o I do not wish to receive text messages regarding appointments and important announcements.
- o I do not wish to receive emails regarding appointments and important announcements.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
*Legal Representative's Printed Name	Legal Representative's Signature	Date

_____
**If representative, specify relationship to patient*