Allergy Free Austin

Dr. Douglas Barstow & Dr. Thomas Leath

Patient Information

Patient's Last Name | First Name and Middle Initial | Social Security Number | Date of Birth

❑ Male ❑ Female

Street Address | City | Zip

❑ Married ❑ Divorced ❑ Single

Primary Phone | Work Phone | Email Address

Emergency Contact | Relation | Phone

Primary Care Physician | How did you hear about us?

Preferred Pharmacy

❑ Doctor
❑ Another Patient
❑ Other:_____(Yelp, website etc)

Responsible/Insured Party Information

Patient's Last Name | First Name and Middle Initial | Social Security Number | Date of Birth

❑ Male ❑ Female

Street Address | City | Zip

❑ Spouse ❑ Parent ❑ Other

Primary Phone | Work Phone | Employer

Consent for Treatment

I do hereby consent to necessary examination procedures and/or treatments prescribed by the physician, his/her assistants, or designees as is necessary in his/her judgement. I understand no warranty of guarantee is made regarding result or cure.

Signature | Date

HIPAA

I have received the brochure "PRIVACY PRACTICES - HIPAA" and have been given the opportunity to read and ask questions to assure that I understand the contents. By signing this form, I consent to the provisions of my patient rights, responsibilities, and sharing of informations indicated by the Notice.

Signature | Date

Assignment of Insurance Benefits

I understand and agree that my signature below provides direct assignment of my insurance policy benefits to the doctor for payment of the total charges for professional services rendered. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my account.

Signature | Date

Patient Responsibility

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on the front of this form and completed the answers. I certify this information is correct to the best of my knowledge. I will notify your office of any changes to the information provided on this form.

Signature | Date

Payment Policy

Payment for services rendered is expected at the time of service, including Co-payments required by the member's contract. HMO/PPO patients will be billed for "Patient Share" balances after insurance pays. The account balance is required to be paid upon receipt of statement. There will be a $25 charge for returned checks and you will be expected to promptly reimburse the practice for the amount of the check and the service charge. There will be a $25 charge for no show appointments not cancelled with a 24 hours notice.

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Authorization to Release Protected Health Information to Family and Friends

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgement in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals (family and friends):

1 _____

2 _____

3 _____

4 _____

5 _____

Please check all boxes that apply. THE PRACTICE STAFF HAVE MY PERMISSION TO LEAVE MESSAGED CONCERNING TREATMENT (i.e. lab results, prescription refills, etc.). ON MY:

❑ Home Answering Machine/Voicemail — Home Phone: _____

❑ Cell Phone Voicemail — Cell Number: _____

❑ Work Voicemail — Work Number: _____

❑ NO INFORMATION: I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided.)

_____ Print Name of Patient

_____ Print Name of Authorized Representative*

_____ Patient/Authorized Representative Signature

_____ Date Signed

*Authorized Representative's authority to act on the patient's behalf:

❑ Parent/Legal Guardian ❑ Power of Attorney

*Evidence of authority must be provided and on file with the practice.