ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

DEMOGRAPHIC INFORMATION

Please provide your insurance card and driver's license to the front desk.

PATIENT INFORMATION

SSN: _____ Preferred Language: _____
First Name: _____ Middle Name: _____ Last Name: _____
Gender: _____ DOB: _____ Marital Status: _____ Ethnicity: _____
Occupation: _____ Employer: _____
Mailing Address: _____
Email Address: _____ Spouse's Name: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

If patient is a minor (under the age of 18):

Guarantor's Name: _____ Address: _____
Mother's Name: _____ Father's Name: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Company Address: _____
Policy #: _____ Group #: _____ Company Phone: _____
Card Holder Name: _____ DOB: _____ SSN: _____
Relationship to Patient: _____ Address: _____
Employer: _____ Employer Phone: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Company Address: _____
Policy #: _____ Group #: _____ Company Phone: _____
Card Holder Name: _____ DOB: _____ SSN: _____
Relationship to Patient: _____ Address: _____
Employer: _____ Employer Phone: _____

PATIENT PAYMENTS: Payment is due at the time of service. There may be a fee for any appointment not canceled 24 hour in advance.

INSURANCE COVERAGE/AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION: We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what insurance plan you are on; please supply us with the correct information at the time of your visit. Some services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some and perhaps all of the services provided may not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered. If you did not update your insurance information at the time of your visit, you will be responsible for a $25.00 refiling fee.

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

PROTECTION OF PATIENT PRIVACY: Our clinic policy prohibits video and audio recordings. By signing below, I acknowledge I will not record any interaction on any electronic device in the clinic.

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION: I have been given access to this practice's Notice Regarding Privacy of Personal Health Information, which explains how my medical information will be used and disclosed.

PHOTOGRAPHS: I understand that Allergy & Asthma Center may use my photograph for treatment and identification purposes.

By signing below, I authorize payment of medical benefits directly to the physician. I authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____

Patient (or Guardian) Signature *Date*

CONTACT INFORMATION

I authorize the Allergy & Asthma Center to call the phone numbers listed below and leave a message on voice mail or give information to persons in reference to my care at this clinic.

Home Phone:_____ Cell Phone: _____
Work Phone:_____ Other Phone: _____

I authorize the clinic to disclose medical information to the persons listed below.

1. Name: _____ Relation: _____
   Home Phone: _____ Cell Phone: _____

2. Name: _____ Relation: _____
   Home Phone: _____ Cell Phone: _____

_____ _____

Patient (or Guardian) Signature *Date*

_____ _____

Patient Printed Name *Date of Birth*

ARE YOU INTERESTED IN RECEIVING INFORMATION OR PARTICIPATING IN CLINICAL TRIALS? Y N

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

INSURANCE VERIFICATION

At the ALLERGY & ASTHMA CENTER, PA, we pride ourselves on offering our patients the highest level of professional care and treatment. We also make every effort to communicate expected charges, payments, insurance benefits and coverage. Our staff will contact your insurance company to verify benefits according to clinic policy or at your request if you know there has been a change to your insurance coverage. However, many factors such as pre-existing conditions, non-covered items and individual benefits purchased by the patient or employer affect the amount actually paid.

We urge all patients to personally contact their insurance company to verify their benefits. We cannot guarantee quoted benefits will be what your insurance company pays.

Please ask to speak to one of our Billing staff if you have questions.

____ I have read the above information and AGREE to have the recommended tests/procedures performed. I also agree to pay for the service if my insurance does not cover the cost.

____ I have read the above information and DO NOT AGREE to have the recommended tests/procedures performed.

_____ _____

Patient (or Guardian) Signature *Date*

_____

Printed Patient Name

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

ALLERGY & ASTHMA CENTER FINANCIAL POLICY

Thank you for choosing ALLERGY & ASTHMA CENTER, PA as your healthcare provider. We are committed to being a patient centered practice and to afford you the best possible treatment in our clinic. We feel communication is important; therefore, we are furnishing you a summary of our financial policy in order to serve your medical needs in a timely, professional and business like manner.

It is important that you read this policy summary carefully and understand your financial obligation.

Our purpose is to explain how we will handle your account so that you can make an informed decision about your medical treatment options and the cost of those treatment options. If you do not understand our policy, please ask and we will be available to explain the policy to you

First, if you have medical insurance, your insurance is a contract between you, your employer, and your insurance company. Our physicians provide a service to you and are not an involved party in the contract you and your employer signed with the insurance company. Insurance reimbursement can be a long and difficult process to understand. In fact, insurers will routinely stall, deny, and reduce payments. We have no control over your insurance companies' reimbursement policies. Should these problems occur we will look to you for timely payment of your account because you are responsible for the prompt payment of services.

In addition, you are responsible for providing us with a current copy of your insurance card each time you visit our office. In the event you do not provide the appropriate insurance within the timely manner set by your insurance carrier, ALLERGY & ASTHMA CENTER, PA will submit a claim to the insurance company; however, your insurance company will not pay for the service. Upon receiving the denial from your insurance carrier, we will send you a statement that will indicate you are responsible for paying the total charges. Please keep in mind we have no way of knowing if your insurance changes unless you tell us. In the event you provided the appropriate insurance information in a timely manner, there should be no problem having the claim filed and your insurance paying accordingly. If you have health insurance and your company does not pay for the service, you are responsible for payment at the time of the visit.

ALLERGY & ASTHMA CENTER, PA will file with your insurance company as a courtesy to you and will absorb all costs incurred for billing. This does not mean that we are **only** accepting what your insurance company pays or that payment will not be required in advance of services. You will be asked to pay that portion which your insurance company says is your responsibility, including any deductible, copayment or coinsurance.

We will not get involved in any disputes you may have with your insurance carrier concerning payment of your claim; however, we will assist in providing medical documentation to the carrier on your behalf. We will expect your prompt payment of the account during the appeal process. Any money due you as a result of the appeal process will be refunded to you in a timely manner.

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

We ask that your calendar year deductible be paid at the time of service. In some instances we may ask that the deductible be paid prior to seeing the physician. For those patients with high deductibles we can assist you by offering a convenient **CareCredit** no interest patient payment option plan should you qualify. Talk to our front office or insurance department staff for details.

Our front office or insurance department staff will discuss the cost of your treatment options with you at the time of your visit. Your initial office visit with ALLERGY & ASTHMA CENTER, PA can range from $75.00 to $350.00 depending on the severity of the problem(s). In addition, if testing is required there will be an additional charge, which could range from $450.00 to $600.00 or higher for special testing ordered, depending on your medical condition. Antigen can be expensive to make.

We can give you an **estimate** of what your insurance will pay; however, we **strongly suggest** you contact your insurance company to verify your part of the expense. We cannot be held responsible for the difference between the estimates we are given by your insurance company and the final payment of the claim. Again, we offer **CareCredit** to our patients as a no interest payment option to assist you with the charges. Our staff can assist you to see if you qualify.

_____ *(Initial here)* I do not have insurance coverage. I understand payment is due at time of service unless prior arrangements have been made.

PLANS IN WHICH WE ARE PARTICIPATING PROVIDERS:

Please **initial** next to your category of insurance listed below, as this will help us speed up payment and eliminate any confusion in the future. Thank you.

_____**HMO Plans:** All co-pays must be satisfied each and every visit. There can be no exceptions due to contracting and uniform compliance rules. You are responsible for getting proper referral information in advance of your appointment. If there is no referral we will give you the option of re-scheduling the visit to another date or time when a referral is provided or pay for the physician services at the time of visit at our current fee schedule rate.

_____**PPO Plans:** We have agreed to accept the discounted rate from your plan; however, all co-pays and co-insurance is your responsibility. We will estimate balances to the best of our ability but we strongly suggest you call your PPO plan to confirm payment plan requirements so there is no confusion. Since the balances are estimates only, we recommend **EASY PAY.** After your insurance has cleared, you may leave the balance on your card; you can send a check or qualify for **CareCredit (**no interest payment option). Please indicate your preference.

_____ Transfer my balance to my credit card
_____ Call first, I might want to send a check
_____ Provide me with information about **CareCredit**

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

_____**Medicare Part B Plan:** Our physicians are participating physicians in the Medicare Part B program. You will not be responsible for any charges above the Medicare Limiting Charge for participating physicians. We will file Medicare Part B for you as a courtesy. We will require that your calendar year deductible and the 20% Medicare Part B **does not** pay, must be paid at the time of service. We recommend **EASY PAY** for your deductible and 20% payment. Immunizations and laboratory services will be billed directly to Medicare Part B and you will not be responsible for these services unless Medicare says the charges are the patient's responsibility. We will include the appropriate claim filing number(s) so Medicare Part B can "cross over" the remaining balance to your Medigap or supplemental carrier for payment. We will ask for payment of services provided and not covered under Medicare Part B program when the service is provided. You will be asked to sign a Medicare waiver form stating you agree to pay for the service prior to receipt of the service.

_____**Medicaid Program:** Medicaid patients are required under the rules of the Texas Department of Health/Medicaid program to bring a copy of their current monthly Medicaid letter confirming eligibility and the primary care physician to each office visit. This is a Medicaid mandate and without this letter/information, we retain the option of rescheduling the appointment.

_____**Chip Superior/Molina Healthcare Plans**: All co-pays must be satisfied each and every visit. There can be no exceptions due to contracting and uniform compliance rules. You are responsible for getting proper referral information in advance of your appointment. If there is no referral we will give you the option of re-scheduling the visit to another date or time when a referral is provided or pay for the physician services at the time of visit at our current fee schedule rate.

Statements are mailed monthly in order that you will know the status of your account with us. It is our policy to transfer the balance to your account for payment if your insurance company does not pay within 45 days. Full payment is due upon receipt of the statement. Our policy is to forward accounts that are 90 days past due from the date of service to a collection agency and you will be responsible for any collection fees and late charges accrued. We strongly recommend that you keep in touch with your insurance carrier to make sure claims are paid in a timely manner and your account be kept current to prevent transfer to collection.

If you have questions about our policy, please ask prior to signing.

_____ _____

Patient Signature *Date*

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

NOTICE OF PRIVACY PRACTICES

Effective Date: September 1, 2013

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.

If you have any questions about this Notice, please contact: JERRY GERSBACH at (254) 751-1144, ext. 390

WHO WILL FOLLOW THIS NOTICE?

- ✓ Niran J. Amar, M.D.
- ✓ Ephraim Thaller, M.D.
- ✓ Neil Amar, M.D.
- ✓ All ALLERGY & ASTHMA CENTER, PA employees

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive care at ALLERGY & ASTHMA CENTER, PA a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES:

ALLERGY & ASTHMA CENTER, PA shall:

- Make every effort to maintain the privacy of your medical information;

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

ALLERGY & ASTHMA CENTER, PA will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment:** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment:** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations:** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run ALLERGY & ASTHMA CENTER, PA in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders:** We may use and disclose medical information in order to remind you of an appointment. For example, ALLERGY & ASTHMA CENTER, PA may provide a written or telephone reminder that your next appointment with ALLERGY & ASTHMA CENTER, PA is coming up.
- **Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your

specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

- **As Required by Law:** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice:** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS

- **Organ and Tissue Donation**: If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel:** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks:** We may disclose medical information about you for public health activities. These activities generally include the following activities:

  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

- **Lawsuits and Disputes:** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If ALLERGY & ASTHMA CENTER, PA determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors:** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates**: If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures:** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for ALLERGY & ASTHMA CENTER, PA. If you request a copy of the information, ALLERGY & ASTHMA CENTER, PA may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

  ALLERGY & ASTHMA CENTER, PA may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by ALLERGY & ASTHMA CENTER, PA will review your request and denial. The person conducting the review will not be the person who denied your request. ALLERGY & ASTHMA CENTER, PA will comply with the outcome of the review.

- **Right to Amend:** If you feel that medical information maintained about you is incorrect or incomplete, you may ask ALLERGY & ASTHMA CENTER, PA to amend the information. You have the right to request an amendment for as long as the information is kept by ALLERGY & ASTHMA CENTER, PA.

  To request an amendment, your request must be made in writing and submitted to ALLERGY & ASTHMA CENTER, PA. In addition, you must provide a reason that supports your request.

ALLERGY & ASTHMA CENTER, PA may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, ALLERGY & ASTHMA CENTER, PA may deny your request if you ask us to amend information that:

- Was not created by ALLERGY & ASTHMA CENTER, PA, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by ALLERGY & ASTHMA CENTER, PA;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list you must submit your request in writing to **Jerry Gersbach** (Administrator). Your request must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. ALLERGY & ASTHMA CENTER, PA will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information ALLERGY & ASTHMA CENTER, PA uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information ALLERGY & ASTHMA CENTER, PA discloses about you to someone who is involved in your care or the payment for your care.

  ALLERGY & ASTHMA CENTER, PA is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which ALLERGY & ASTHMA CENTER, PA has been paid out of pocket in full. Should ALLERGY & ASTHMA CENTER, PA agree to your request, ALLERGY & ASTHMA CENTER, PA will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions you must make your request in writing to ALLERGY & ASTHMA CENTER, PA. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit ALLERGY & ASTHMA CENTER, PA's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications:** You have the right to request that ALLERGY & ASTHMA CENTER, PA communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that ALLERGY & ASTHMA CENTER, PA contact you only at work or by mail.

  To request that ALLERGY & ASTHMA CENTER, PA communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. ALLERGY & ASTHMA CENTER, PA will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with ALLERGY & ASTHMA CENTER, PA or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with ALLERGY & ASTHMA CENTER, PA, contact the Privacy Officer at 254-751-1144, ext #390. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that ALLERGY & ASTHMA CENTER, PA provided me with a written copy of its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature *Date*

_____ _____

Personal Representative Signature (if applicable) *Relationship to Patient*

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient for whom authorization is made:

Full Name: _____ Date of Birth: _____

Other Name(s) Used: _____

Address: _____

Phone: _____ Email (*Optional*): _____

Entity authorized to disclose this information: ALLERGY & ASTHMA CENTER, PA

N. J. Amar, M.D. Ephraim Thaller, M.D. Neil K. Amar, M.D.

Who can receive and use this information: *(separate form needs to be filled out for each individual/entity)*

Name: _____

Address: _____

Phone: _____ Fax: _____

Specific information to be disclosed:

Medical Record from (insert date) _____ to (insert date) _____

_____ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, demographics and records received from other health care providers.

_____ Other: _____

Include: (*Indicate by Initialing*)

_____ Drug, Alcohol or Substance Abuse Records
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Mental Health Records (Except Psychotherapy Notes)
_____ Genetic Information (Including Genetic Test Results)

Reason for release of information: *(Choose all that Apply)*

_____ Treatment/Continuing Medical Care
_____ Personal Use
_____ Billing or Claims
_____ Insurance
_____ Other *(Specify)*: _____
_____ School
_____ Employment
_____ Legal Purposes
_____ Disability Determination

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

The individual signing this form agrees and acknowledges as follows:

- **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- **Effective Time Period:** This authorization shall be in effect until the earlier of two years after the death of the patient for whom this authorization is made or the following specified date: _____ / _____ / _____.
- **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal Representative: _____ Date: _____
Relationship to Patient: _____
Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

Name: _____ DOB: _____

Describe the reason or your visit today: _____

I. HISTORY OF PRESENT ILLNESS

ALLERGIES

If you have nasal allergies, please indicate your symptoms:

☐ Stuffy nose	☐ Sneezing	☐ Bad breath	☐ Itchy throat
☐ Runny nose	☐ Nosebleeds	☐ Hoarseness	☐ Sore throat
☐ Postnasal drip	☐ Snoring	☐ Itchy eyes	☐ Loss of taste
☐ Throat clearing	☐ Loss of smell	☐ Watery eyes	☐ Headache
☐ Itchy nose	☐ Mouth breathing	☐ Itchy ears	☐ Nasal polyps

Other symptoms: _____

How long have you had allergies? _____ What time of day is worse? _____

Do you have symptoms year round? _____ Which months are worse? _____

Indicate if you have allergy symptoms with the following triggers:

☐ Trees	☐ Cats	☐ Windy days	☐ Alcoholic beverages
☐ Grass	☐ Dogs	☐ Cold temps	☐ Spicy foods
☐ Weeds	☐ Feathers	☐ Fragrances	☐ Exercise
☐ Molds	☐ Smoke	☐ Strong odors	☐ Menstrual cycle
☐ Dust	☐ Smog	☐ Chemicals	☐ Stress

Other triggers _____

How often do you have sinus infections? _____

If you have had CT scans of your sinuses, please list the dates _____

If you have had skin testing, please list the dates _____

If you have been on allergy injections, please list the dates _____

ASTHMA

If you have asthma, please indicate your symptoms:

☐ Daytime symptoms	☐ Difficulty getting air in	☐ Chest tightness
☐ Nighttime symptoms	☐ Difficulty getting air out	☐ Wheezing
☐ Shortness of breath	☐ Symptoms with exercise	☐ Cough

Other symptoms: _____

What triggers your asthma symptoms? _____

What time of the year does your asthma worsen? _____

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

Name: _____ DOB: _____

Is your physical activity restricted due to asthma? _____
How often do you use your rescue inhaler? _____
How often have you needed steroids for asthma? _____
Number of missed school/work days due to asthma: _____ Number of ER visits for asthma: _____
Number of hospitalizations for asthma: _____ Have you ever been intubated? _____
If you have had CT scans of your chest, please list the dates: _____

ECZEMA OR RASHES

Do you have eczema? _____ When did it start? _____
Describe your rash: _____
What medicines have you used for the rash? _____
What soaps and lotions do you use? _____
Have you had a biopsy? If yes, when? _____

HIVES OR SWELLING

Do you have hives or swelling? _____ When did it start? _____
Describe your symptoms: _____
What have you used for the symptoms? _____
Have you had a biopsy? If yes, when? _____

OTHER ALLERGIES

Do you have a food allergy? _____
If yes, list the foods and reactions: _____
Do you continue to eat these foods? _____
Have you had a life threatening reaction to an insect sting? _____
If yes, please list the insects and reactions: _____

II. PAST MEDICAL HISTORY

Please indicate if you have been diagnosed with the following conditions:

☐ Heart disease	☐ Diabetes	☐ Hypertension	☐ Depression
☐ Sleep apnea	☐ Cataracts	☐ High cholesterol	☐ Anxiety
☐ Pneumonia	☐ Glaucoma	☐ Thyroid disease	☐ Cancer
☐ COPD	☐ Reflux disease	☐ ADHD	☐ HIV/AIDS

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

Name: _____ DOB: _____

Other medical conditions _____
If you have had the following surgeries, please list the dates:
Sinus surgery _____ Tonsillectomy _____ Adenoidectomy _____ Ear tubes _____
Other surgeries: _____
List the dates for the following vaccines: Influenza _____Pneumoccoal ("Pneumonia") _____

List all your current medications including vitamins and supplements:

Medication	Dosage	Frequency	Reason for taking medication

Do you have an epinephrine autoinjector? _____
List any medication allergies and reactions: _____

_____

Are you allergic to latex? _____ If yes, what are your symptoms? _____

III. SOCIAL HISTORY

Occupation _____ Who lives at home with you? _____
Marital status _____ If you have children, please list their ages: _____
Do you currently smoke? _____ If yes, # of cigarettes per day _____ For how long? _____
Did you smoke in the past? _____ If yes, # of cigarettes per day _____ For how long? _____
When did you quit? _____
Is there anyone in your home that smokes? _____ If yes, do they smoke indoors or outdoors? _____
Do you drink alcohol? _____ If yes, how often?_____
Do you use illicit drugs? _____ If yes, what kind and how often?_____
If you exercise, what type and how often? _____
List your hobbies: _____

ENVIRONMENTAL HISTORY

Do you have pets? _____ What kind and how many? _____
Do the pets live indoors or outdoors? _____ Do they sleep in the bedroom? _____

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

Name: _____ DOB: _____

How old is your home? _____
What types of plants are around your home? _____
How long have you lived in Central Texas? _____
Where did you live prior to Central Texas? _____

IV. CHILDREN UNDER 12 YEARS OLD

Were there any complications during pregnancy or childbirth? _____
Does the child go to day care? _____ What grade is the child in? _____
If the child has siblings, please list their ages: _____
Has the child has RSV infection in the past? _____

V. FAMILY HISTORY

If anyone in your family has been diagnosed with the following conditions, please specify the relation:

Asthma _____ Food allergy _____ Hives _____
Hay fever _____ Eczema _____ Other _____
Father's age: _____ If deceased, age and cause of death: _____
Mother's age: _____ If deceased, age and cause of death: _____

VI. REVIEW OF SYSTEMS

Indicate if you have the following symptoms:

☐ Fever	☐ Weight gain	☐ Abdominal pain	☐ Visual changes
☐ Chills	☐ Weight loss	☐ Urinary infections	☐ Dizziness
☐ Fatigue	☐ Cold intolerance	☐ Blood in stool	☐ Fainting
☐ Chest pain	☐ Heat intolerance	☐ Insomnia	☐ Muscle pain
☐ Palpitations	☐ Nausea	☐ Anxiety	☐ Joint pain
☐ Leg swelling	☐ Vomiting	☐ Memory loss	

Please provide any other information you think may be helpful in assisting in your care: _____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

ALLERGY ASTHMA CENTER

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

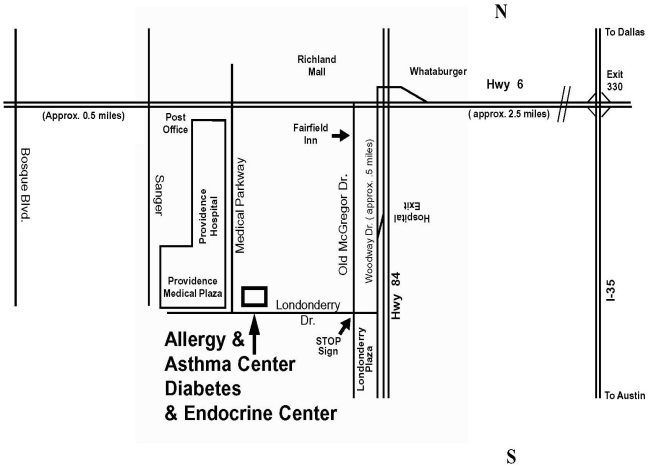
ALLERGY SKIN TESTING

To prepare for your allergy skin test, please do not take any antihistamines or medications that contain antihistamines for five (5) days before your appointment (common antihistamines listed below). Please continue all your asthma medications. If you have questions regarding other medications you are taking, please call our office and check with the nursing staff.

Any non-barbituate sedative	Compazine	Meclazine	Robitussin Nighttime
with the name "PM", "sleep	Compoz	Medi-flu	Rondec Syrup
aid" or "nighttime"	Comtrex	Methscopolamine	Ru-Tuss
Acrivastine	Contac/Ornade	Midol	Ryna-C
Actifed	Contac Severe Cold & Flu	Mizolastine	Rynatan
Adapin	Coricidin	Naldecone	Rynatuss
Alavert (loratadine)	Cotab AX, Cotab Flu	Naphcon-A eye drops	Scot-Tussin
Alfen DMA	CoTylenol Cold Forumla	Nolahist	Semprex, Semprex D
Alka-Selzer Plus Cold & Cough	Cyproheptadine	Nolamine	Sine-Off
Allegra, Allegra-D	Dallergy	Norel DM, Norel SR, Norel LA	Sinubid
Aller-Chlor	Deconamine SR	Novafed-A	Sinulin
Allerhist	Desloratadine	Novahistine DH liquid	Sinutab
Allerest	Dexbrompheniramine	Nytol	Sominex
AlleRx	Diphedryl	Nyquil Multi-Symptom	Sudafed Plus
Antivert	Diphen	Nyquil Nighttime Cold	Sudal-12
Astelin Nasal Spray	Diphenhydramine	Opcon-A eye drops	Tagamet
Astemizole	Dimetane	Optimine	Tanafed
Astepro Nasal Spray	Dimetapp	Optivar eye drops	Tavist-1
Atarax	Doxepin	Ornade	Tavist-D
Atrohist	Dramamine	Orthoxicol	Theraflu Flu, Cold & Cough
Axid	Dristan	Palgic	Theraflu Maximum Strength
Azatadine	Drixoral	Pamprin	Thorazine
Azelastine	Drixoral Cold & Flu	Pataday eye drops	Trinalin
Benadryl (diphendyramine)	Drixoral Cold & Allergy	Patanase nasal spray	Triprolidine
Benylin	Duratuss	Patanol eye drops	Triaminic Nighttime
Bepreve eye drops	Dura-Vent	PBZ	Triaminicin
Brexin	Dymista Nasal Spray	Pediox-S	Tussend
Bromfed	Elestat eye drops	Pepcid	Tussionex
Brompheniramine	Emadine eye drops	Periactin	Tylenol PM
Brovex	Extendryl	Phenergan	Tylenol Allergy, Cold & Flu
Calm-Aid	Fedahist	Phenindamine	Unisom
Carboxinoxamine	Fexofenadine	Phenyltoloxamine	VasoBid, VazoTan
Cerose DM	4 Way Cold	Polarmine	Vicks 44 Cough, Cold & Flu
Cetirizine	Genahist	Polyhistine-D	Vistaril
Cheracol-Plus	Hycomine	Poly-DM Syrup	Visine-A eye drops
Cheracol-Sinus	Hydramine	Premysn	Zaditor eye drops
Chlo-Amine	Hydroxyzine	Promethazine	Zantac
Clarinex, Clarinex-D	Isochlor	Pyrilamine	Zyrtec, Zyrtec-D
Claritin, Claritin-D (loratadine)	Kronafed	Pyrroxate	Xyzal
Chlorafed	Livostin	Pyrlex, Pyrlex PD	Zymine HC, Zymine-D
Chlorpromazine	Lodrane, Lodrane D	Quelidrine	Zymine liquir
Chlor-Trimeton	Loratadine	Ranitidine	
Chlorpheniramine	Maxichlor PSE DM	Rescon	
Codimal	Maxiphen ADT	Rezine	

N. J. Amar, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Ephraim Thaller, M.D.
Board Certified in Allergy & Immunology and Pediatrics
Neil Amar, M.D.
Board Certified in Allergy & Immunology and Internal Medicine

DIRECTIONS TO ALLERGY & ASTHMA CENTER



FROM US 84 (TRAVELING EAST)

- Exit Sante Fe/Texas Central Parkway (stay in the left lane).
- Turn LEFT at the stoplight onto Sante Fe and proceed through next stoplight.
- At the four-way stop, turn RIGHT onto Old McGregor Road. Stay on this street for 0.3 miles.
- At second four-way stop, turn LEFT onto Londonderry Drive. Travel 0.2 miles.
- Office is on the right, just before Providence Hospital.

FROM HWY 6

- Take Sanger Avenue exit.
- Stay on the access road. Travel past the Post Office.
- Turn RIGHT onto Medical Parkway.
- Our office is on the left corner of Medical Parkway and Londonderry Drive.

FROM US 84 (TRAVELING WEST)

- Take Londonderry Drive exit.
- Turn RIGHT onto Londonderry Drive. Travel 0.3 miles.
- Our office is on the right, just before Providence Hospital.

FROM I-35

- Exit TX-6 North/Meridian (Exit 330).
- Follow curve to merge onto TX-6/TX Loop 340.
- Travel on TX-6 for 2.5 miles.
- Take exit on to US 84/Waco Drive.
- Stay in the middle lane; proceed through first stoplight.
- Turn LEFT at second light; go under TX-6 overpass.
- Go straight through next light. Travel 0.5 miles to Londonderry Drive.
- Turn RIGHT onto Londonderry Drive. Travel 0.3 miles.
- Office is on the right, just before Providence Hospital.

SATELLITE CLINICS

MEXIA
514 S. Bonham, Suite D
Mexia, TX 76667

HILLSBORO
1323 E. Franklin, Suite 103
Hillsboro, TX 76645

GATESVILLE
1507 W. Main Street
Gatesville, TX 76528