DENTON NORTH
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Phone: (940) 382-4142
Fax: (940) 382-7620

PROSPER
1970 W. University Dr.
Suite 110
Prosper, TX 75078
Phone: (940) 382-4142
Fax: (940) 382-7620

NORTH TEXAS ALLERGY & ASTHMA CENTER

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Phone: (940) 387-1700
Fax: (940) 382-7620

GAINESVILLE
217 N. Weaver St.
Gainesville, TX 76240
Phone: (940) 665-3247
Fax: (940) 382-7620

Medical History

Name _____ Date of Birth _____ Date of Visit _____

Gender _____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language _____

Race(s) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Primary Care Physician _____ City _____

Pharmacy _____ Location _____

How did you find out about our practice? _____

Reason for your visit _____

Current ongoing medical problems _____

Previous resolved medical problems _____

Past surgeries (include approximate date) _____

Current prescription, OTC and herbal medications (include dose/frequency) _____

_____

_____

Previous allergy and asthma medications tried (include oral medications, inhalers, nasal sprays and eye drops) _____

_____

Most effective allergy and asthma medications (from above) _____

Please list names and approximate dates of any antibiotics taken in last year _____

_____

Please list approximate dates of any oral steroids taken in last year_____

Please list any known allergies (chemicals, foods, insect stings, latex, medications, etc.) _____

_____

Are you up to date on your immunizations? _____ Have you had an adverse reaction to any vaccine? _____

Date of most recent flu vaccine (if any) _____ Date of most recent pneumonia vaccine (if any) _____

Please list any major infections requiring hospitalization _____

How many times have you had pneumonia? _____ Do you have a history of TB or TB exposure? _____

How many times have you had sinusitis or bronchitis in the last year? _____How many ear infections have you had in the last year? _____

Please list any allergy, asthma, immune or autoimmune problems in your family and the family member's relation to you _____

_____

Review of Systems: Please circle any symptoms you are currently experiencing below

Constitutional:	Fevers	Chills	Night sweats	Fatigue			
Eyes:	Vision changes	Itching	Tearing	Redness	Swelling		
ENT:	Drainage	Nose bleeds	Congestion	Sinus pain	Ear pain	Ear ringing	Sore throat
Respiratory:	Coughing	Wheezing	Tightness	Shortness of breath	Bloody sputum		
Cardiovascular:	Chest pain	Palpitations	Dizziness	Exercise intolerance			
Gastrointestinal:	Heartburn	Bloody stools	Vomiting	Diarrhea	Constipation	Abdominal pain	Cramping
Urinary:	Blood in urine	Painful urination	Difficulty urinating	Low back pain			
Neuro:	Headache	Seizures	Numbness	Weakness			
Hematology:	Unusual bleeding	Easy bruising	Swollen nodes				
Skin:	Hives	Eczema	Dry skin	Itching	Swelling		
Endocrine:	Weight loss	Weight gain	Cold intolerance				
Psychology:	Anxiety	Depression	Increased Stress				

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Patient Financial Advisory

Patient's Name _____ Date of Birth: _____

Please initial each line that you have read our policies on each type of plan/services:

Non-Covered Services

_____ (initials) I understand North Texas Allergy & Asthma Center (NTAAC)'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 reschedule the appointment or pay for the visit out-of-pocket at the time of service.

Self-Pay Accounts

_____ (initials) Self-pay accounts are (1) those with no available health insurance coverage at the time of service or (2) those that are covered by an insurance carrier with which NTAAC 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 NTAAC 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 NTAAC if services are deemed "non-covered."

Services Rendered

_____ (initials) I agree that in return for services provided to the patient by NTAAC, the account balance will be paid at the time service is rendered or I will make appropriate financial arrangements satisfactory to NTAAC 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 NTAAC. 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 the office manager.

- As a courtesy, NTAAC 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 $50 no-show fee.
- 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

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Consent for Use and 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: Our office promises not to 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. Our office complies with HIPAA and all federal and state laws regarding the privacy of your information. A copy of our Notice of Privacy Practices document is available to you at any time at our office.

You may refuse to sign this authorization.

Acknowledged and agreed to by:

Patient or Parent Signature _____ Date _____

Patient Name _____

Patient DOB _____

Optional Disclosure of Protected Health Information

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

Name _____ Relationship _____

Date of Birth _____ Phone Number _____

Name _____ Relationship _____

Date of Birth _____ Phone Number _____

Due to the nature of our practice, please refrain from wearing or using scented lotions, perfumes or colognes.

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Testing Requirements

All Allergy Testing requires you to stop certain medications:

If you are planning on having (please initial each line even if you are not having these tests done today):

____ SKIN PRICK TEST (SPT) you must be off any antihistamines for 7 days prior to the appointment.

____ PATCH TESTING you must be off any oral steroids for 21 days prior to the application of the patches.

____ CHALLENGES (Drug/Food/Venom) you must be off antihistamines for 7 days prior to the appointment.

PRIOR TO GOING TO THE LAB, YOU ARE STRONGLY ENCOURAGED TO:

- CONTACT YOUR INSURANCE COMPANY FOR BENEFITS
- SPECIFICALLY ASK IF ANY OF THE LABS REQUIRE ANY PRIOR AUTHORIZATION
- MAKE SURE THAT THE LAB IS IN NETWORK FOR YOUR PLAN

____ Our office <u>does not</u> bill your insurance for any laboratory services. In addition, we do not know how your insurance pays for laboratory services or how the lab will code these charges.

____ Our office cannot be held responsible for any billing issue that you may have between the laboratory and your insurance company.

____ We DO NOT have any contract with any lab and therefore have no input on how they bill and/or appeal charges with your insurance company.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____
Legal Representative's Printed Name	Legal Representative's Signature	Date
_____		_____
If representative, specify relationship		Staff Initials/Date

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Text, Voicemail and Email Authorization

We offer text and/or email messaging for appointment reminders and important announcements. By providing your cell phone number and email address below, you grant North Texas Allergy & Asthma Center permission to contact you regarding upcoming appointments and important announcements by text or email.

*****Please keep in mind that communications via email over the internet are not secure*****

RISK OF USING E-MAIL: Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from North Texas Allergy and Asthma Center are not encrypted, so E-mails may not be secure. Therefore, it is possible that the confidentiality of such communications may be breached by a third party.
b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) E-mail senders can easily misaddress an E-mail.
d) E-mail is easier to falsify than handwritten or signed documents.
e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail can be used to introduce viruses into computer systems.
i) Practice server could go down and E-mail would not be received until the server is back on-line.
j) E-mail can be used as evidence in court.

As part of routine patient care, it may be necessary to contact our patient(s) by telephone. In the event you are not available by phone, we may leave a detailed voicemail message regarding your/your child's treatment with your consent. By providing your telephone number(s) below, you grant North Texas Allergy & Asthma Center permission to leave detailed voicemail messages regarding your/your child's treatment.

Mark box below if you DO NOT wish to receive Text, voicemails and/or emails:

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

☐ I do not wish to receive texts regarding appointments or important announcements.

☐ I do not wish to receive emails regarding appointments or important announcements.

PATIENT ACKNOWLEDGMENT AND AGREEMENT
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail. If I have any questions, please contact our office North Texas Allergy and Asthma Center 940-382-4142.

Patient's Printed Name	Patient's Signature	Date

Legal Representative's Printed Name	Legal Representative's Signature	Date

If representative, specify relationship

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Cancellation & No-Show Policy

Our office requires 24-hour notice for all appointment cancellations.

Missed or cancelled appointments with less than 24-hour notice will be subject to an automatic $50 no-show fee. This fee will have to be paid in full to reschedule any future appointments.

For your convenience, North Texas Allergy & Asthma Center offers text message and email appointment reminders. Please notify the front desk if you have not set this up.

I have read the above cancellation and no-show policy and agree to the terms.

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

_____

If representative, specify relationship

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Telemedicine Consent:

1. **Introduction**: Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real time.

2. **Consent for Treatment**: I voluntarily request North Texas Allergy & Asthma Center physician(s) and such associates, technical assistants, and other health care providers as they may deem necessary ("North Texas Allergy & Asthma Center Telemedicine Providers") to participate in my medical care through the use of telemedicine.

I understand that North Texas Allergy & Asthma Center Telemedicine Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that North Texas Allergy & Asthma Center Telemedicine Providers' advice, recommendation, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent obtained for anyone other than my health care provider present in the room. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in the medical record. I also understand that my refusal will not affect my right to future care or treatment. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.

I understand that my health care information may be shared with other individuals for scheduling and billing purposes. I understand that my insurance carrier will have access to my medical records for quality review/audit. I understand that I will be responsible for any out-of- pocket costs such as copayments, coinsurances, or deductibles that apply to my telemedicine visit. I understand that health insurance plan payment policies for telemedicine visits may be different from policies for in-person visits.

I consent to having my health care plans and general instructions regarding my health sent to me by email and/or conventional mail.

If North Texas Allergy & Asthma Center Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my physician and, in the case of emergencies, dial 911, or go to the nearest hospital emergency department.

3. **Release of Information**: To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to North Texas Allergy & Asthma Center Telemedicine Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information; 2) drug screen results, information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

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I understand that the disclosure of my medical information to North Texas Allergy & Asthma Center Telemedicine Providers, including audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I certify that I am located in the state of Texas and will be in Texas during my telemedicine visit(s).

I, the patient or patient's representative and the North Texas Allergy & Asthma Center Telemedicine Providers rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1): that all health care rendered shall be governed exclusively and only by Texas law and in no event shall the law of any other state apply to any health care rendered to the patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas court in the county/district where all or substantially all of the health care was provided or rendered (not received) and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.
This telemedicine, email and mail consent will remain in effect as long as telemedicine services are offered by North Texas Allergy & Asthma Center and applies to new patient and all follow-up visits going forward.

_____ _____

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: _____

Patient Complaint Procedure: While we hope that every patient's visit goes smoothly, it is important that we are notified of patient concerns so that we can address them. If you have comments, questions, or concerns, we recommend that you or your representative discuss them with your immediate caregiver or speak to the office manager. Complaints about physicians, as well as other licenses and registrants of Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board Attention Investigations 333 Guadalupe, Tower 3, Suite 610 PO Box 2018, MC-263 Austin, TX 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1- 800-201-9353. For more information, visit the Texas Medical Board website at www.tmb.states.tx.us

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AI-Assisted Documentation Consent Form

Patient Name_____Date of Birth _____

At North Texas Allergy & Asthma Center, we are committed to providing high-quality medical care while incorporating technology that enhances efficiency and accuracy. As part of your care, your provider may utilize secure, HIPAA-compliant artificial intelligence ("AI") technology to assist with clinical documentation during your visit. AI-assisted documentation helps streamline the creation of clinical notes and supports comprehensive and precise medical records, allowing your provider to focus more directly on you during your appointment.

Understanding AI-Assisted Documentation

- The AI technology used in your appointment assists with transcribing and summarizing discussions between you and your medical provider. Audio is processed in real time and is not stored.
- The AI tool is only used to support medical documentation and does not make clinical decisions or replace the expertise and judgement of your provider.
- Your information is encrypted, kept confidential, and is not shared with unauthorized third parties.
- Your provider will review, edit, and finalize all AI-generated documentation to ensure accuracy and completeness.
- All AI-assisted documentation is handled in compliance with HIPAA regulations to safeguard your privacy and protected health information.

Your Rights

- Participation in AI-assisted documentation is voluntary.
- You may decline or withdraw consent for the use of AI-assisted documentation at any time without affecting the quality of your care.
- You have the right to have ask questions regarding AI-assisted documentation at any time, and your provider or clinic staff will be happy to address any concerns.

By signing below, you acknowledge that you have read and understand the information provided about AI-assisted documentation. You acknowledge that you have had the opportunity to ask questions and receive answers regarding the use of AI-assisted documentation.

☐ I **consent** to the use of an AI transcription tool to record and transcribe my visits for the purpose of assisting my provider with documentation. I understand that my provider remains responsible for all medical decisions and documentation entered into my medical record.

☐ I **do not** consent to the use of an AI transcription tool to record or transcribe my visits. I understand that this will not affect the quality of my care.

Patient/Guardian Signature _____Date _____

Provider/Witness Signature _____Date _____