Devora Center for Allergy, Asthma & Immunology

PATIENT INFORMATION

NAME ____ DATE OF BIRTH _____________________

ADDRESS____ CITY/STATE__________________ ZIP_________

SSN ____________________ SEX: Male Female MARITAL STATUS _________________________

HOME PHONE ______________________ WORK ______________________ CELL_____________________

EMAIL ____

EMPLOYER ____

ADDRESS _______________________________________CITY/STATE__________________ ZIP___________

REFERRED BY ____

INCASE OF EMERGENCY – CONTACT INFORMATION

NAME _____________________________ RELATION_____________________ PHONE_________________

PRIMARY INSURANCE INFORMATION

INSURANCE ____________________________________ INSUREDS NAME____________________________

DOB: ___________________ SSN ________________ RELATIONSHIP TO PATIENT ____________________

INSURED ID __________________________________ GROUP NUMBER ______________________________

INSURED EMPLOYER ____

SECONDARY INSURANCE INFORMATION

INSURANCE ____________________________________ INSUREDS NAME ____________________________

DOB: ___________________ SSN ________________ RELATIONSHIP TO PATIENT ____________________

INSURED ID __________________________________ GROUP NUMBER ______________________________

INSURED EMPLOYER ____

PATIENT SIGNATURE/AUTH REPRESENTATIVE ____________________________ DATE ________________

Devora Center for Allergy, Asthma & Immunology

PATIENT REGISTRATION FORM DISCLOSURE & CONSENTS

PATIENT NAME: ____ DATE OF BIRTH: ______________

ASSIGNEMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to the above physician for services rendered to my dependents or myself, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay, coinsurance or balance due that my provider is unable to collect from my insurance carrier.

MEDICARE INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependents records that these programs may request. I hereby direct that payment of my, or my dependents authorized benefit be made directly to the physician on my behalf.

TESTING:

Patients should expect to receive notification for results of any testing including labs and radiology within a reasonable time frame. We will attempt to contact you, but in the event we are unsuccessful it is the patient's responsibility to contact the office for results. If you are scheduled for a visit to review your results we will discuss all testing at the time of your visit. If you miss the appointment to review it is your responsibility to contact the office to reschedule.

TREATMENT:

We make the best effort to diagnose and treat your condition(s) based upon the information obtained. Sometimes diseases and conditions may evolve. If you do not improve or your condition worsens and/or changes, it is your responsibility to inform us so we may re-evaluate your condition and diagnosis.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment as directed by my provider or those under his/her supervision.

CANCELLATION, LATE AND NO SHOW POLICY:

Our office policy requires patients who request to cancel or reschedule their appointment to call our office at least 24 hours prior to their scheduled visit. A $25.00 No Show/Cancellation fee may be assessed to you if the office is not contacted according to the policy. This fee applies to any patients that do not show up for their scheduled appointment. The office will attempt to confirm your appointment in advance. Please note insurance companies cannot be billed for missed appointments. Please arrive on time for your appointment. If you are late the office may ask you to reschedule out of courtesy for those patients scheduled after you.

Patient/Authorized Representative Signature: ________________________________Date: __________

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PATIENT REGISTRATION FORM DISCLOSURE & CONSENTS

AUTHORIZATION TO MAIL, CALL OR EMAIL:

I ____ understand the privacy risks of the mail, phone calls and email and hereby authorize Devora Center for Allergy, Asthma & Immunology, designated provider(s) and those under his/her supervision and/or representatives to mail, call or email me with communications regarding my healthcare. This includes, but not limited to such things as appointment reminders, referral arrangements and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Devora Center for Allergy, Asthma & Immunology to that effect in writing.

I certify understanding of the following:

● Email should never be utilized for an urgent or emergency problem.

● Providers are not required to communicate via email and that this is up to the discretion of the provider.

● Email should never be used for time sensitive issues.

● Email is not confidential and should not be used for sensitive information.

● All emails will become part of the permanent medical record.

● Email responses may not receive an immediate response. Responses may take a full business day or more.

● The provider(s) will not be responsible for information loss, delay or breaches in confidentiality that are due to technical factors beyond the office's control.

● I agree that I may send medical related correspondence to you via email and that I may respond to your emails to use via email.

THE HIPPA PRIVACY RULES GIVE PATIENTS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). PATIENTS ARE ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS DISCLOSURES OF PHI TO BE MADE BY ALERTNATIVE MEANS, SUCH AS SENDING CORRESPONDANCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THEIR HOME.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY) Initials____________

Home Phone	○ Okay to leave a detailed message.
	○ Leave message with call back number only.
Work Phone	○ Okay to leave a detailed message.
	○ Leave message with call back number only.
Mobile Phone	○ Okay to leave a detailed message.
	○ Leave message with call back number only.

Written Communication	○ Okay to leave a detailed message.
	○ Leave message with call back number only.
Fax/Email	○ Okay to leave a detailed message.
	○ Leave message with call back number only.

Patient/Authorized Representative Signature: _________________________________Date: __________

Devora Center for Allergy, Asthma & Immunology

PATIENT REGISTRATION FORM DISCLOSURE & CONSENTS

PAYMENT POLICY

I understand and acknowledge the following:

- We will file insurance for our PPO, HMO and other managed care patients.
- Verification of benefits given to us by your insurance company is not a guarantee of payment.
- All copays, deductibles and/or coinsurance are due at the time of services rendered according to insurance contract provisions.
- We cannot guarantee payment of your claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.
- We accept assignment and will file for our Medicare patients. Any calendar year deductible amount, to the extent of the visit amount, are due at the time of service if applicable. Patients will be responsible for 20% if there is no secondary insurance. If a secondary is available, we will file secondary insurance after payment from Medicare.
- There is a $25 fee assessed for any returned check. You will subsequently receive a bill for this amount. Payment will need to be made in the form of cash, money order or VISA/MC. If payment is not received by the due date, your information will be turned over the Collin County District Attorney. Any returned check will immediately restrict any future acceptance of checks as payment on your account.
- Late fees may apply to accounts past due 90 days.
- If your policy is an HMO, you are responsible for contacting your insurance prior to your visit and assigning provider. Failure to do so may result in claim denial and you will be responsible for the balance due on account.
- If any patient is owed a refund, all claims on the account must be processed and paid in full before overpayment is refunded. If account is eligible, refunds will be processed 30 days from the date we are made aware of the refund due.
- Failure to provide the correct and accurate information regarding insurance in order to file claims accurately and timely could result in claim denial, therefore may result in patient responsibility.
- If your insurance requires a referral, it is your responsibility to obtain this prior to your appointment. Failure to obtain will result in the rescheduling of your appointment.
- I authorize release of medical records to determine liability for payments or treatment and to obtain reimbursement.

I certify that I have read, acknowledge and understand Devora Center for Allergy, Asthma & Immunology Patient Registration Form Disclosures & Consents. This complete and full Disclosure and Consent Form assignment will remain in effect until revoked by me in writing. A photocopy and/or electronic copy of this instrument will have the same validity as the original.

Patient/Authorized Representative Signature: ________________________________Date: __________

Devora Center for Allergy, Asthma & Immunology

PATIENT REGISTRATION FORM DISCLOSURE & CONSENTS

NOTICE OF PROVACY PRACTIVIES & HIPPA RELEASE OF INFORMATION

I certify and acknowledge that I have read and been made available a copy of the Notice of Privacy Practices. I understand the Notice of Privacy Practices provides information on how we may use and disclose protected health information (PHI). The Notice contains information regarding your rights under the law. The terms of our Notice may change. If we change our Notice you will obtain a revised copy during your next office visit. You have the right to request that we restrict PHI about you for treatment, payment or healthcare operations. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that PHI may be disclosed or used for treatment, payment or healthcare operations. The practice has the Notice posted and available for patients to review. The practice reserves the right to change the Notice of Privacy Practices. The practice reserves the right to restrict the uses of their information but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing at any time and all further disclosures will cease.

This authorization expires at the end of each calendar year or is revoked by the patient in writing. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

Finally, you may revoke this authorization in writing at any time by sending a written notification to Devora Center for Allergy, Asthma & Immunology. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Initials: ______________

PLEASE CHOOSE ONE:

____ I do not wish my information to be disclosed to any person.

____ I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s).

Name ______________________________ Relationship ____________________ Phone ____________

Name ______________________________ Relationship ____________________ Phone ____________

Name ______________________________ Relationship ____________________ Phone ____________

Name ______________________________ Relationship ____________________ Phone ____________

Name ______________________________ Relationship ____________________ Phone ____________

Patient Name (print) ____________________________________ Date ________________________

Patient/Authorized Representative Signature ____

DEVORA CENTER
FOR
ALLERGY, ASTHMA & IMMUNOLOGY
GENE A. DEVORA, MD/PHD

New Patient Questionnaire

Name:____**Date:**___________________

General Information	
Date of birth:	**Age:**
Referring physician:	
Primary care physician:	

OFFICE
Texas Health Presbyterian Hospital
Medical Office Building #2
6300 W. Parker Road, Suite G22
Plano, TX 75093

PHONE
(972) 981-3692

FAX
(972) 981-3605

WEB
www.genedevoramd.com

SERVICES:

- Seasonal allergies
- Food allergies
- Asthma
- Eczema
- Contact dermatitis
- Hives
- Drug allergies
- Eosinophilic esophagits
- Celiac disease
- Recurrent infections
- Allergy skin testing
- Allergy shots/drops
- Food allergy testing
- Oral food challenges
- Asthma
- Xolair
- Patch testing
- Penicillin allergy testing
- Immune system evaluation
- Registerd dietitian consults

Reason for Visit (circle all that apply):		
Hay Fever/Allergies	Food Allergy	Sinus Infections
Nose Problems	Reaction to Insect Stings	Rash or Itchy Skin
Hives	Asthma or Difficulty Breathing	Reaction to Medications
Swelling	Frequent Infections	Eosinophilic Esophagitis
Other:		

Current Medications:	Dose	# of times per day taken	Date Started

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Allergies to Medications: [ ] check here if no known medication allergies

Medication	Reaction

Past Medical History: [ ] check here if no medical problems

Medical Condition	Date of Onset

Past Surgical History: [ ] check here is no surgeries

Surgery	Date

Immunizations:

Flu vaccine this season? yes no

Have you ever had a pneumonia shot? yes no

When?

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Social History:

Alcohol (circle one): never occasional regular

How many drinks per week?

Tobacco use: never quit current

When did you quit?

How much do you smoke?

Smokers at home: yes no

Drugs of abuse: yes no

Which drugs?

What type of work do you do?

Family History:
Do any of YOUR FAMILY members (excluding yourself) have any of the following?

Asthma: yes no	**Relationship**:
Hay Fever/Nasal Allergies: yes no	**Relationship:**
Eczema: yes no	**Relationship:**
Problems with the Immune System: yes no	**Relationship:**
Other:	**Relationship:**
Other:	**Relationship:**
Other:	**Relationship:**

Environmental History:

Current home: house apartment mobile home

Carpeting in home? yes no

Carpeting in: bedrooms living room den hallway

Pets: dog cat birds other

Allergy covers on bedding? none pillows mattress

Ceiling fans? yes no

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Review of Systems (Check yes or no):		Yes	No	Date of Onset
General	Appetite changes			
	Fatigue			
	Fever/chills			
	Weight changes			
Eye	Cataracts			
	Glaucoma			
ENT	Congestion			
	Runny nose			
	Hoarseness			
	Postnasal drip			
	Decreased sense of smell			
	Nasal polyps			
	Sinus pressure			
	Headaches			
	Nose bleeds			
Heart	Chest pain			
	Palpitations			
Lung	Shortness of breath			
	Wheezing			
	Cough			
	Snoring			
GI	Abdominal pain			
	Diarrhea			
	Constipation			
	Trouble swallowing			
MS	Joint pain			
	Weakness			

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Review of Systems (Check yes or no):		Yes	No	Date of Onset
Neuro	Numbness			
	Seizures			
Skin	Hives			
	Rash			
	Swelling			
	Eczema			
	Itching			
Psych	Depression			
	Anxiety			
Heme	Anemia			
	Bleeding tendency			
	Lymph node swelling			
Endo	Heat intolerance			
	Cold intolerance			
	Excessive thirst			
	Excessive urination			
GU	Pain with urination			
	Trouble urinating			

Additional Information: (use this space or back page if needed)

Doctor's Signature:______________________________ **Date:**__________