ESTABLISHED PATIENT UPDATE

Location: ☐ Plano ☐ McKinney ☐ Allen ☐ Denison
Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____ Gender: _____
Primary Email: _____ Primary Phone Number: _____
Primary Care Physician: First Name: _____ Last: _____ City: _____
Briefly describe the Main reason for your visit today: _____
Please list all prescription medications you take regularly or as needed: (Name of Drug, Dose and Frequency of use): ☐ None

_____

_____

_____

Please list all Over the Counter (OTC) medications you take regularly or as needed: (Name of Drug, Dose and Frequency): ☐ None

_____

_____

List all FOOD allergies/intolerances: ☐ None _____
List all MEDICATION allergies/intolerances: ☐ None _____
List all INSECT or CHEMICAL allergies/intolerances: ☐ None _____
Have you received this season's FLU shot? ☐ Yes ☐ No ☐ Unknown If yes, date: _____
Have you ever received the Pneumonia shot Pneumovax? ☐ Yes ☐ No ☐ Unknown If yes, date: _____
Have you ever received the Pneumonia shot Prevnar 13? ☐ Yes ☐ No ☐ Unknown If yes, date: _____
Please indicate your preferred local Pharmacy NAME, CITY, STREET: _____
Do your prefer Liquid or Tablet medications? ☐ Liquid ☐ Tablet
Please list any NEW information regarding your health since your last visit? Indicate recent surgeries, illnesses, new diagnoses, etc:
☐ None _____
Have you had any changes in your social status since your last visit (job, residence, tobacco/alcohol use/ allergen exposure):
☐ Yes ☐ No If Yes, please specify: _____
Have you had any changes in your Family History since your last visit (relative with new illnesses or disease):
☐ Yes ☐ No If Yes, please specify: _____

Review of Systems/ Please select ANY signs/symptoms/conditions that you currently experience: ☐ None

Constitutional: ☐ Fatigue ☐ Night Sweats ☐ Fevers

GI: ☐ Indigestion ☐ Reflux ☐ Vomiting ☐ Diarrhea ☐ Trouble Swallowing

Frequent infections: ☐ Sinus ☐ Lung ☐ Ear/Throat ☐ Bronchitis ☐ Skin

Eyes: ☐ Blurry ☐ Itch ☐ Water ☐ Red ☐ Frequent Infections

Nose: ☐ Runny ☐ Stuffy ☐ Itchy ☐ Sneeze ☐ Loss of Smell

Skin: ☐ Dry ☐ Itch ☐ Swelling ☐ Rash ☐ Hives

Hematology: ☐ Unusual Bleeding ☐ Unusual Bruising ☐ Swollen Lymph Nodes

Respiratory: ☐ Short of Breath ☐ Wheeze ☐ Cough ☐ Croup ☐ Tight Chest

Urinary: ☐ Urinary Infection ☐ Blood in Urine ☐ Back Pain

Musculoskeletal: ☐ Stiff/Sore Joints ☐ Muscle Pain ☐ Red Swollen Joints

Chest: ☐ Slow Heart Rate ☐ Palpitations ☐ Tight ☐ Chest-Pain ☐ Fast Heart

Neuro: ☐ Numbness ☐ Seizures

Psychology: ☐ Anxious ☐ Depressed ☐ Stressed ☐ Worried

Endocrine: Weight ☐ Gain / ☐ Loss ☐ Increased Thirst ☐ Cold/ ☐ Heat Intolerance

My signature indicates that the above information is accurate to the best of my knowledge.

_____	_____	_____
Patient/Guardian Name	Patient/Guardian Signature	Date Updated

In office use: Reviewed by: JV GS MB TC AH LB LR

In office use: Signature of the Provider: _____

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*