# ALLERGY & ASTHMA CENTER AT WAXAHACHIE

**2460 N. I-35, Suite 220 Waxahachie, Texas 75165**
**Office (972) 923-9200 Fax (972) 923-9201**

SCOT A. LAURIE, MD

DIPLOMATE, AMERICAN BOARD
ALLERGY AND IMMUNOLOGY

Name:_____ Age: _____ Date:_____

Please answer all questions. This information sheet will be reviewed during your visit with your doctor.

1. What is the primary reason for your visit to the office?

   _____

   _____

2. What is your main goal for this visit?

   _____

3. Do we treat any of your family members? If so, can you please tell me their name?

   _____

**What symptoms do you have?**

1. Nasal symptoms: (If you do not have nasal symptoms, please skip to 2)
   a. Congestion ----------->Yes No
   b. Drainage ----------->Yes No
   c. Sneezing ----------->Yes No
      i. Do you sneeze four or more times in a row?---->Yes No
   d. Itching ----------->Yes No
   e. When did your nasal symptoms begin? _____
   f. Seasonal, or year-round symptoms? _____
   g. If seasonal, what are your worst seasons? _____

2. Respiratory symptoms: (If you have no respiratory symptoms, please skip to 3)
   a. Chest tightness ----------> Yes No
   b. Shortness of breath ----------> Yes No
   c. Wheezing ----------> Yes No
   d. Cough ----------> Yes No
   e. Have you been diagnosed with asthma? ----------> Yes No
      i. If so, when? _____
   f. Have you been hospitalized because of asthma? --------> Yes No
      i. If so, when? _____
   g. Have you visited an emergency room because of asthma? Yes No
      i. If so, when? _____
   h. If you have asthma, what makes your asthma worse? (e.g. exercise, stress, heat or cold, etc)

      _____

      _____

3. Skin symptoms: (If you have no skin symptoms, please skip to 4)
    a. Eczema ----------> Yes No
    b. Hives ----------> Yes No
    c. Swelling ----------> Yes No
        i. What parts of the body does the swelling affect?

        _____

        _____

    d. Rash ----------> Yes No
        i. What parts of the body does the rash affect?

        _____

        _____

4. Eye Symptoms: (If you have no eye symptoms, please skip to question 5)
    a. Itching ----------> Yes No
    b. Watering ----------> Yes No
    c. Redness ----------> Yes No

5. Previous Evaluation
    a. Have you seen a doctor for any of the above problems? Yes No
    b. What are the names of the doctors?

    _____

    _____

    c. What treatments did you try?

    _____

    _____

    _____

    d. Have you been allergy tested? ----------> Yes No
        i. If yes, when, where, and by what doctor?

        _____

        ii. If yes, what were you allergic to?

        _____

        _____

    e. Have you ever taken allergy shots? ----------> Yes No
        i. If yes, when, how long, and with what doctor?

        _____

        _____

6. What medications are you currently taking (please include dose and frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

7. Please list any reactions to any medications in the past:

_____

_____

8. Environmental

   a. How long have you lived in the area? _____
   b. Where did you live previously? _____
   c. How long have you lived in your current residence? _____
   d. How old is your current residence? _____
   e. Do you have pets? ----------> Yes No
      i. If yes, how many and what kind?

      _____

      _____
   f. Do you have carpeting in your bedroom? ----------> Yes No
   g. Do you have any areas of water damage in your home, or areas of visible mold growth? ----------> Yes No
   h. Are there any smokers in the home? ----------> Yes No

9. Social

   a. What is your occupation? _____
   b. Do you exercise? ----------> Yes No
      i. If yes, what type of exercise do you do and how often?

      _____

      _____
   c. Do you smoke now or have you in the past? ----------> Yes No
      i. If yes, when, how much and for how long?

      _____
   d. Do you have any children or grandchildren, or do you work with any young children? ----------> Yes No

10. Medical History

   a. What other medical problems are you being treated for or have you been diagnosed with?

      _____

      _____

      _____
   b. Have you ever been admitted to a hospital? ----------> Yes No
      i. If so, when and what for?

      _____

      _____
   c. Have you had any operations? ----------> Yes No
      i. If so, what operations?

      _____

      _____
   d. Do allergies or asthma run in your family? ----------> Yes No

i. If so, which family members and what conditions do they have?

_____

_____

11. Review of Systems: Please circle any symptom that bothers you a significant part of the time. You will be given the opportunity to discuss these symptoms with one of our staff.

e. GENERAL: Recent weight change; weakness; fatigue; fever

f. SKIN: lump, sores, itching, dryness, changes in hair or nails

g. HEAD: Headache or head injury

h. EYES: Vision changes, pain, redness, excessive tearing, double vision, blurred vision, glaucoma or cataracts

i. EARS: Hearing changes, tinnitus, vertigo, earaches, infection, discharge

j. NOSE AND SINUSES: Frequent colds, nasal congestion, discharge, nasal itching, sinus trouble, nosebleeds, postnasal drip.

k. MOUTH AND THROAT: Problems with teeth or gums, dentures, sore tongue, frequent sore throat, hoarseness.

l. NECK: Lumps, goiter, pain or stiffness in the neck.

m. RESPIRATORY: Cough, sputum, coughing up blood, wheezing, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy, date of last chest x-ray and result:

_____

n. CARDIAC: Heart trouble, high blood pressure, rheumatic fever, heart murmurs, chest pain or discomfort, palpitations, shortness of breath, shortness of breath when lying down, edema, waking up at night because of shortness of breath.

o. GASTROINTESTINAL: Trouble swallowing, heartburn, appetite, nausea, vomiting, indigestion, change in bowel habits, rectal bleeding, black or tarry stools, hemorrhoids, constipation, diarrhea, abdominal pain, jaundice, liver or gallbladder trouble, hepatitis

p. URINARY: Frequency of urination, frequent urination at night, burning or pain with urination, blood in urine, urgency, reduced urinary stream, dribbling, incontinence, urinary infection, kidney stones.

q. MUSCULOSKELETAL: Muscle or joint pain, stiffness, arthritis, gout, backache.

r. NEUROLOGIC: Fainting, blackouts, seizures, weakness, paralysis, numbness, loss of sensation, tingling, tremors.

s. HEMATOLOGIC: Anemia, easy bruising or bleeding, past transfusions and any reactions to them.

t. ENDOCRINE: Thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst or hunger.

u. PSYCHIATRIC: Nervousness, tension, depression, anxiety, memory problems

# Allergy & Asthma Center at Waxahachie

Scot Laurie, M.D.

Date_____ Patient Acct # _____

Patient's Last Name_____ First Name_____
Address_____ City_____ State_____ Zip _____
Sex_____ Age_____ Date of Birth _____ SS#_____
Drivers License #_____ Home Phone_____
Work Phone _____ Cell Phone_____
Email Address_____ Fax_____

Name of Responsible Party (if other than patient) _____
Address (if different) _____City_____ State_____
Home Phone _____Cell Phone _____ Work Phone_____
Name of Nearest Relative not living with you_____
Relationship _____ Home Phone _____Work Phone_____
**Please list other members of your family that are patients here & their relationship:** _____
Emergency Contact _____ Phone #_____
Cell#_____Work#_____
**Pharmacy Info- Location**_____
**Pharmacy Telephone #**_____

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**Who recommended our office?** _____
What is your medical coverage? _____

HMO EPO/POS PPO INDEMNITY MEDICARE

PRIMARY INSURANCE INFORMATION
ID #_____
Insurance Company Name:_____ Group # _____
Claims billing address _____
Insured Name _____ Relationship to patient _____
Male Female SS#_____ DOB of insured _____
Employer Name: _____ Address: _____
City _____ State_____ Zip_____

Secondary Insurance Company _____Group#_____
Claims Address _____City _____ State_____ Zip_____
Insured _____ Relationship to Patient _____ Male Female
SS#_____ DOB _____ Employer _____

## Scot Laurie, MD, P.A.

## Allergy & Asthma Center at Waxahachie

### Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

# ALLERGY & ASTHMA CENTER

**at Waxahachie**

## FINANCIAL AGREEMENT

### INSURANCE

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referrals and authorization requirements. We will, however, assist you to ensure that all plan requirements are met. **X_____ (PLEASE INITIAL)**

### PAYMENT FOR SERVICES

**Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.** We accept cash, checks, MasterCard, Visa and American Express. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative. **X_____ (PLEASE INITIAL)**

### RETURNED CHECK

Returned checks will result in a **$ 25.00 fee that will be posted to your account.** Returned checks, balances older than 60 days, and failure to pay account balances attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt. **X_____ (PLEASE INITIAL)**

### CANCELLED APPOINTMENTS

Charges may be made for broken, confirmed appointments cancelled without 48 hour notice. Your cooperation in canceling your scheduled appointment well in

advance allows us the opportunity to offer your appointment to a person who needs medical care. X_____ **(PLEASE INITIAL)**

**GENERAL**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

**Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.**

**X_____ (PLEASE INITIAL)**

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

Thank you,

**My signature below constitutes acknowledgement and acceptance of this policy.**

Patient Name:
(Please Print)

_____

Patient or guarantor Signature:

_____ Date _____

Scot Laurie M.D.

Patient Record of Disclosure:

We have your permission to disclose medical information/results about yourself or minor patient to the following people. If left blank, we will not be able to advise anyone or your medical status or address questions they ask on your behalf.

Patient's name:_____

DOB:_____

1. Name:_____ Relationship_____
2. Name:_____ Relationship_____
3. Name:_____ Relationship_____
4. Name:_____ Relationship_____

Should any information change, it is your responsibility to advise of your change and you will need to complete a new disclosure. Otherwise, we will not be held responsible for releasing information to a party you wish to no longer access your information.

Patient Signature:_____Date:_____

## Scot Laurie, MD, P.A.

## Allergy and Asthma Center at Waxahachie

# Notice of Privacy Practices

**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.**

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPPA) require that Allergy and Asthma Center at Waxahachie/Mansfield ("the practice") provide you with this Notice Regarding Privacy Personal Health Information. This Notice describes: 1. how the practice may use and disclose your protected health information; 2. your rights to access and control your protected health information in certain circumstances; and 3. the practice's duties and contact information.

### I. PROTECTED HEALTH INFORMATION

" Protected health information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present, or future physical or mental health; the provision of health care to you; and your past, present, or future payment for health care.

### II. USES AND DISCLOSURES

***Treatment***: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

***Payment***: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

***Health care operations:*** Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

***Other uses and disclosures include appointment reminders:*** Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail and ***information about treatments***: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

## III. ADDITIONAL USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION OR AN OPPORTUNITY TO OBJECT

In addition to treatment, payment, and healthcare operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

***When legally required:*** The practice will comply with any Federal, state, or local law that requires it to disclose your protected health information

***When there are risks to Public Health:*** The practice may disclose your protected health information for public health purposes, including to, as permitted or required by law:

1. Prevent, control, or report disease, injury, or disability
2. Report vital events such as birth or death
3. Conduct public health surveillance, investigations, and interventions;
4. Collect or report adverse events or product defects; track FDA-regulated products; enable product recalls, repairs, or replacements; and conduct post-marketing surveillance.
5. Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease
6. Report to an employer information about an individual who is a member of the workforce.

***To report abuse, neglect, or domestic violence:*** As required or authorized by law or with the patient's agreement, the practice may inform government authorities if it believed that a patient is the victim of abuse, neglect or domestic violence

***To conduct health oversight activities:*** The practice may disclose your protected health information to a health oversight agency for use in: 1. audits; 2. civil, administrative, or criminal investigations, proceedings, or actions; 3. inspections; 4.licensure or disciplinary actions; or 5. other necessary oversight activities as permitted by law. However, if you are the subject of an investigation, the practice will not disclose protected health information that is not directly releated to your receipt of health care or public benefits.

***For judicial and administrative proceedings:*** The practice may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by such order or a signed authorization is provided.

***For law enforcement purposes:*** The practice may disclose your protected health information to a law enforcement official for law enforcement purposes when:

1. Required by law to report certain types of physical injuries
2. Required by court order , court-ordered warrant, subpoena, summons, or similar process
3. Needed to identify or locate a suspect, fugitive, material witness, or missing person
4. Needed to report a crime in an emergency situation

***To coroners, funeral directors, and for organ donation:*** The practice may disclose protected health information to a coroner or medical examiner for the purpose of 1. identification; 2. determination of cause of death; 3. performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the practice may disclose protected health information, including when death is reasonably anticipated, to a funeral director, to enable the funeral director to carry out his or her duties. Protected health information may also be used and disclosed for the purpose of cadeveric organ, eye or tissue donation.

***For research purposes:*** The practice may use or disclose your protected health information for research if such use or disclosure has been approved by an institutional review board or privacy board that has examined the research proposal and the research protocols which maintain the privacy of your protected health information.

***For specified government functions:*** As authorized by the HIPPA privacy regulations, the practice may use or disclose your protected health information to facilitate specified government functions relating to military and veterans' activities, national security and intelligence activities, protective services for the

President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

***For worker's compensation:*** The practice may disclose your health information to comply with worker's compensation laws or similar programs.

## IV. USES AND DISCLOSURES PERMITTED WITH AN OPPORTUNITY TO OBJECT

Subject to your objection, the practice may disclose your protected health information: 1. to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care; or 2. when attempting to locate or noticy family members or others involved in your care to inform them of your location, condition, or death. The practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not object to these disclosures, the practice is able to infer from the circumstances that you do not object, or the practice determines, in its professional judgement, that it is in your best interests for the practice to disclose information that is directly relevant to the person's involvement with your care, then the practice may disclose your protected health information. If you are incapicitated or in an emergency situation, the practice may exercise its professional judgement to determine if the disclosure is in your best interests, and if such a determination is made, may only disclose information relevant to your health care.

## V. INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

## VI. PRACTICE DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

## VII. RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

## VIII. REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

## IX. COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address shown below. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

## X. CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
2460 N I-35 East, Suite 220
Waxahachie, TX 75165

**EFFECTIVE DATE: THIS NOTICE IS EFFECTIVE ON OR AFTER APRIL 14, 2003**