ALLERGY & ENT ASSOCIATES

Health Care Provider Team

Allergy & ENT Associates Healthcare Provider Team consists of Allergists, Otolaryngologist (ENT), Nurse Practitioners and Physician Assistants. The physician you select for your care is your "Team Leader" and PRIMARY ENT/ ALLERGIST. He or she may work with a Nurse Practitioner or Physician Assistant. From time to time, you may have an office visit with another Group Physician, the Nurse Practitioner, or the Physician Assistant.

Your PRIMARY ENT/ALLERGIST supervises your care, regardless of which type of health care provider delivers care. At any time you can request to see your PRIMARY ENT/ALLERGIST and will be scheduled to be seen as soon as possible. Nurse Practitioners are Advanced Practice Registered Nurses with advanced education and training in the provision of health care. A Nurse Practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. The Physician Assistant also has extensive education and training in the delivery of health care, and can diagnose, treat and monitor your care. A visit with an alternate group physician, the Nurse Practitioner, or the Physician Assistant will expedite prompt treatment of illness and/or efficient follow-up assessment when your primary allergist does not have immediate availability. Please visit our website at www.aentassociates.com for more information about our practice and healthcare team.

PRIVACY/COMMUNICATIONS

Allergy & ENT Associates Patient Portal is hosted by NextMD. We are excited to provide this service to you as an enhancement to our existing commitment to outstanding patient care. As a new patient to our practice, you will use this portal to complete new patient registration. This service is made available to Allergy & ENT Associates' patients for no additional charge. We provide this to enhance our level of service and not as a substitute to face-to-face care. NextMD is a secure website and your personal health information is protected by existing state and federal privacy laws. The information you provide on this site will only be accessed and used by Allergy & ENT Associates.

In addition to telephone calls, we now have the capability to communicate with you via Email and Text Messages. You can review our privacy policy by visiting our website at www.aentassociates.com. There may be interruptions and technical difficulties associated with the use of this technology and understand that the portal may not always be available.

GRIEVANCES

If you have any questions, complaints or concerns please contact us at:

Allergy & ENT Associates, ATTN:Executive Director
450 Gears Rd. Ste. 420 Houston, TX. 77067
Tel: (281) 875-8428 Fax:(281) 874-0018

You may also register a complaint with the Texas State Board of Medical Examiners at:

Texas Medical Board, Attention: Investigations
333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263 Austin, Texas 78768-2018
Tel:(800) 201-9353

If you have Medicare and are not satisfied after you have tried to speak directly to people involved in providing your services, or if you are not satisfied the information you received is correct,you may contact the Medicare Ombudsman by mail at:

HHS Office of the Ombudsman
P.O. Box 13247 Austin, Texas 78711-3247
Tel: 877-787-8999 Fax: at:888-780-8099

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign and convey directly to my above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above – named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and /or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/ or insurance reimbursement above, I also assign and/or convey to the above-named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort for insurance concerning medical expenses incurred as a result of the medical services, treatment, therapies, and/or medication I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named health care provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatment, therapies, and/or medication provided by the above-named health care provider, including right to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator.

The above named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. **I HAVE READ AND FULLY UNDERSTAND THIS ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION.**

ALLERGY & ENT ASSOCIATES

Please Mark with an "x" **Registration Type: _____NEW Patient ____NEW BENEFITS/INSURANCE**

PATIENT INFORMATION:

Patient Name:_____ **DOB:**____/____/____ **Age:** ____ **Sex:** __M __F
First Middle Last

Home Address:_____
Number/Street/Apt # City State Zip Code

Email Address: _____ **SS #**_____

Cell Tel#:(_____)_____ **Home Tel#:**(_____)_____ **Work Tel#:**(_____)_____

Marital Status: __ **Married**__**Single**__**Divorced**__**Widow** **PCP/Pedi/MD:**_____**Tel#:**_____

Emergency Contact:_____ **Relationship:** _____ **TEL#:** (_____)_____

DISCLOSURE INFORMATION:

I authorize Allergy & ENT Associates to disclose or provide any and all protected personal health information to:_____ **Relationship to Patient:**_____

RESPONSIBLE PARTY: Check here if: ☐ Same as patient

Name:_____**DOB:** ____/___/_____**SS# of Responsible Party:**_____

Home Address:_____ **Sex:**____**Male** ____**Female**
Number/Street/Apt # City State Zip Code

Relationship to Patient:_____ **Preferred Telephone #:**(_____)_____

INSURANCE INFORMATION: Check here if:☐My Benefits Have Changed Since My Last Visit

Subscriber Name:_____**Date of Birth:** _____/_____/_____
First Middle Last

Primary Insurance: _____ **Group #:** _____

Policy #:_____**Employer:**_____

FINANCIAL STATEMENT:

I understand that I am financially responsible for all services not covered by my insurance company. I understand that if my insurance company requires that I have a referral to see a Provider at Allergy and ENT Associates,it is my responsibility to obtain the referral prior to my appointment. If I am unable to do so, my appointment may be rescheduled or I may be expected to pay for the charges in full at the time of service. I hereby authorize payment to any physician of Allergy & ENT Associates who has treated my dependents or me for medical services rendered. Allergy & ENT Associates will make every effort to contact your insurance company to verify your benefits. However, verification of insurance benefits is not a guarantee of payment. If the insurance company denies payment or services that are not covered, the Policyholder will become financially responsible for those services.

CANCELLATION FEE:

I understand that if I do not give a minimum of 48 hours notice for cancellation of allergy skin testing appointments, I will be billed a $50 cancellation fee that is not covered by the insurance plan. Failure to cancel office visit appointments at least 24 hours prior to the appointment will result in a $30 charge.

PRIVACY PRACTICES:

I have received or was offered a copy for review of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive my own copy of this document. Allergy & ENT Associates reserves the right to modify the privacy practices outlined in their notice.

SUMMARY ACKNOWLEDGEMENT:

I acknowledge that I have received Information and Notices for the **Healthcare Provider Team**, **Grievances**, **Assignment of Benefits/ Release of Information, Patient/Insurance Information Form, Financial Statement,Cancellation Fees, and Privacy Practices Acknowledgment;** I have been given the opportunity to ask questions, understand, and agree, to the information as presented/ provided. I have reviewed the information provided and insure its accuracy.

Today's Date: _____/_____/_____

_____ _____
Patient Name (Print) **Signature of Patient or Guardian/Personal Representative**

_____ _____
Name of Guardian/Personal Representative (Print) **Description of Guardian/Personal Representative's Authority**