# ASTHMA & ALLERGY CARE ASSOCIATES

MAUREEN McGEEHAN, M.D., P.A., FAAAAI
WILLIAM NEAVILLE, M.D., P.A.

399 W. CAMPBELL RD
SUITE 308
RICHARDSON, TEXAS 75080
469-330-0800
FAX 469-330-0803

Date: _____ For office use – Chart number:_____

PATIENT'S NAME_____DATE OF BIRTH_____

ADDRESS_____HOME TEL #_____
Street Apt #
_____MOBILE #_____
City State Zip

EMPLOYER_____WORK TEL #_____

DRIVER'S LICENSE #_____ EMAIL ADDRESS:_____

REFERRED BY_____
Name Address, phone if you would like a letter sent

II. RESPONSIBLE PARTY INFORMATION:
NAME OF INSURED_____DOB:_____
(Please complete if different than above.)

RELATIONSHIP TO PATIENT_____ PREFERRED CONTACT NUMBER:_____

ADDRESS_____
Street Apt # City Zip

INSURED'S EMPLOYER_____

PRIMARY INSURANCE:_____POLICY #_____GROUP #_____

SECONDARY INSURANCE:_____POLICY #_____GROUP #_____

III. ADDITIONAL DEMOGRAPHIC DATA

This information is used to measure delivery of healthcare services; collecting accurate data is the basic foundation to identify differences and improve the quality of care:
Language spoken _____ Marital status (please circle): single married divorced widowed other

American Indian or Alaskan:_____ Asian:_____ Black or African American:_____
Caucasian:_____ Latino or Hispanic:_____ Pacific Islander:_____
Other:_____ I decline to answer:_____

IV. PREFERRED PHARMACY: _____
Name phone address

V. CONSENT FOR TREATMENT:
I consent to examination, diagnosis and treatment as prescribed by the attending physician. I authorize the use or disclosure of my medical records or other personal health information as needed for purposes of treatment, payment (if requested by the insurance company to process claims) or healthcare operations. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I authorize payment of medical benefits to the physician for services received at this office. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____DATE_____
Patient/Parent Signature
Emergency Contact : _____ Relationship to patient_____Phone#_____

ASTHMA & ALLERGY CARE ASSOCIATES

MAUREEN McGEEHAN, M.D., P.A., FAAAAI
WILLIAM NEAVILLE, M.D., P.A.

399 W. CAMPBELL RD
SUITE 308
RICHARDSON, TEXAS 75080
469-330-0800
FAX 469-330-0803

# Patient Information Contact Form

Name:_____ Date:_____

Do we have permission to contact you at the following numbers?

Y/N Home _____
Y/N Cell Phone _____
Y/N Work _____
Y/N Other _____

May we leave a message for you at work? Y/N What is your preferred number?_____
May we leave a message for you at home? Y/N

Email:_____

In addition to you and your insurance company, with whom may we discuss your health information?

Y/N Spouse Name/Telephone _____
Y/N Caregiver Name/Telephone _____
Y/N Child Name/Telephone _____
Y/N Parent Name/Telephone _____
Y/N Other Name/Telephone _____

Do you have any health information that you would like to keep confidential from any person(s)? Y/N
If so, please describe: _____
_____
_____
_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information and the opportunity to specify alternative means of communication of my protected health information.

I acknowledge that I have reviewed this office's Notice of Privacy Practices, and that I may request a copy of the Privacy Notice.

_____ _____
Patient or Personal Representative Signature Date

_____ _____
Printed Name Relationship to Patient

ASTHMA & ALLERGY CARE ASSOCIATES

MAUREEN McGEEHAN, M.D., P.A., FAAAAI
WILLIAM NEAVILLE, M.D., P.A.

399 W. CAMPBELL RD
SUITE 308
RICHARDSON, TEXAS 75080
469-330-0800
FAX 469-330-0803

## Office Policies

- Payment is due at the time of service, but if you have medical insurance with one of our contracted providers, we will assist you by filing your claims. We must emphasize that your insurance is a contract between you, your insurance company, and potentially your employer. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are provided. It is your responsibility to be familiar with the terms of your plan, including whether a referral is needed, if a deductible applies, the dates of active coverage, etc.

- We accept cash, checks, master card, visa, and discover, with proper identification. There is a $35 fee for returned checks.

- In the event of inclement weather, we may close in order to allow our staff to get home safely. We follow the policy of the Richardson Independent School District. If there is inclement weather during school holidays, please call ahead to confirm that we are open.

- Our office regularly closes for certain national holidays, and rarely for other reasons. Every attempt is made to post these closings with at least 4 weeks' notice, both in our office and on our website, www.richardsonallergy.net .

- Please call during regular office hours for prescription refills and to schedule appointments.

- A physician is available by phone after regular office hours for urgent issues only. In the event of a medical emergency, please call 911, but for urgent issues that cannot wait until regular office hours, please call 972-854-1137

- If an appointment must be rescheduled or cancelled, notice of at least one business day is required. If sufficient notice is not given, a $35 fee may be assessed.

Our top priority is providing the best medical care possible. These policies are in place to promote a mutually satisfactory relationship. If you have questions or concerns about our policies, please contact one of our staff.

ASTHMA & ALLERGY CARE ASSOCIATES

MAUREEN McGEEHAN, M.D., P.A., FAAAAI
WILLIAM NEAVILLE, M.D., P.A.

399 W. CAMPBELL RD
SUITE 308
RICHARDSON, TEXAS 75080
469-330-0800
FAX 469-330-0803

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

Patient Name: _____

I acknowledge that Asthma and Allergy Care Associates provided:

- a copy of the Notice of Privacy Practices
- a copy of the Office Policies

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and the office policies, and ask questions.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient