ALLERGY & IMMUNOLOGY
MEDICAL CENTER

NEW AND ESTABLISHED PATIENT CONSENT FORM

I. Consent to Treat

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by the physician(s) of Allergy & Immunology Medical Center, their staff and designees, as may be in their professional judgement, deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical treatment and procedures.

II. Health Insurance Portability and Accountability Act Notice

I acknowledge that I have signed and reviewed the **Health Insurance Portability and Accountability Act (HIPAA) Notice Regarding Privacy of Personal Health Information (PHI).**

I understand and agree to allow the Allergy & Immunology Medical Center to use my PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. If you would like a more detailed account of the policy and procedures concerning the privacy of your PHI, we direct you to read the HIPAA Notice that is available for you at the front desk before signing this consent form.

III. Use of Electronic Communications

I agree and understand that I may use electronic methods to communicate with the Allergy & Immunology Medical Center regarding my care and treatment but use is discouraged due to privacy concerns. Our office will make a reasonable attempt to return all electronic messages in a timely manner. Communication via telephone or in person is recommended as email does not meet HIPAA security standards. Thus, our clinic's use of email will be limited.

- Telephone calls may have an expected **turnaround time of 24 to 48 hours**. Please note that Fridays are administrative days and telephone calls will not be answered.
    - Any calls after-hours that are answered by our on-call physician will be subject to a **$25.00 fee** which will be automatically charged to my credit card on file as a self-pay cost, irrespective of my insurance coverage.
- Emails are discouraged due to health information privacy concerns as above and may take up to a one week response time and will receive a limited response. Please note that Fridays are administrative days and emails will not be answered.

I understand that requests for forms and lab results that are sent via email are not HIPAA protected. The Allergy & Immunology Medical Center may keep copies of electronic messages that I send to my physician and his staff. A written request for lab results needs to be physically returned to our office at **248 Addie Roy Road Suite B201, Austin, Texas, 78746**. Although not recommended due to privacy concerns, your request may also be emailed to office@aimedcenter.com.

IV. Request for Medical Records

I understand that I am responsible for cost of medical records. Per Texas Medical Board Rules, the Medical Practice Act, copy fees for medical forms in paper format will be charged as follows:

- **$25.00** for the first 20 pages
- **$0.50** for each additional page thereafter

The office will attempt to fulfill requests for medical records promptly; however, the turnaround time for fulfilling medical record requests **may take up to 30 days** in accordance with federal regulations. According to the Texas Medical Practice Act, consent for released of medical records must be in writing. A written request for medical records needs to be physically returned to our office at **248 Addie Roy Road, Suite B201, Austin, Texas, 78746**. Although not recommended due to privacy concerns, your request may also be emailed to office@aimedcenter.com.

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V. Request for Prescription Refills

I understand that all refill requests for prescriptions need to be brought up at my appointment. In the event that a prescription needs to be refilled, I understand that I need to contact the office via telephone and may need to schedule an appointment with Dr. Patel to discuss my medication usage, tolerance, and benefits.

The office will attempt to fulfill prescription refill requests in order of urgency; however, I understand that the expected turnaround time **may be up to 3 days**. Please plan ahead accordingly for future prescription refills that you may need. Please note that Fridays are administrative days and refill requests will not be fulfilled.

VI. Forms

I understand that it is my responsibility to schedule an appointment to ensure there is sufficient time for completion of all forms prior to the date needed. Please plan ahead accordingly as appointment availability is dependent on the schedule. Completion of any forms, including work, school, and recreational, will require an appointment with Dr. Patel. Please bring a copy of all forms that need to be completed and signed by Dr. Patel to your appointment.

- If you are unable to make an appointment, there will be a **$25.00 charge** to complete any of the forms listed above.

VII. "No Call, No Show" Fee

I understand that if I am unable to keep my appointment then I will notify the Allergy & Immunology Medical Center **at least 24 hours in advance** to avoid a **$50.00 cancellation fee**. I acknowledge that I will be automatically charged the **$50.00 cancellation fee** to my credit card on file irrespective of my insurance coverage if I do not notify the Allergy & Immunology Medical Center **at least 24 hours in advance**, and will be contacted via telephone that the charge has been made.

VIII. Outstanding Balances

I authorize the Allergy & Immunology Medical Center to keep my **credit card information on file.** The office will make reasonable attempts to contact the patient or account holder regarding outstanding balances via mail, telephone and email. I acknowledge that I will be automatically charged for any outstanding balances at the Allergy & Immunology Medical Center that are **90 days past due from the date of service** and I will be contacted via telephone that the outstanding balance has been charged.

Any questions or concerns regarding outstanding balances can be directed towards our outsourced billing company, **NobilityRCM**, via telephone at **1-(888)-501-6638**.

IX. Insurance and Billing:

Insurance plans are highly variable regarding coverage of office visits, treatments and procedures. Some insurance plans cover costs in full, while other plans have have unit restrictions, associated deductibles, co-insurances, and co-pays resulting in partial coverage, or have no coverage at all. .

I understand that it is my responsibility to contact my insurance carrier to find out about my insurance coverage and personal responsibility of the cost.

I acknowledge that I am authorizing the Allergy & Immunology Medical Center to bill my insurance company and that any costs incurred that is not covered by my insurance carrier, such as deductibles, co-insurances, or co-pays, will be my financial responsibility.

X. Termination

This agreement may be terminated by Dr. Ojas Patel and his staff if he determines that I have failed to comply with the provisions specified in this agreement.

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PATIENT CONSENT:

I have read and fully understand the consent form, and consent to the terms. I understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms contained in this consent form.

IF YOU HAVE ANY QUESTIONS OR CONCERNS ASK YOU DOCTOR NOW **BEFORE SIGNING THIS CONSENT FORM.**

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM!

SIGNATURE WILL BE COLLECTED ELECTRONICALLY AT RECEPTION DESK