Houston Rheumatology and Allergy Clinic
6550 Fannin, Suite 2421
Houston, TX 77030
Ph: 281-888-9870 Fax: 713-422-2336

## Patient Information

Name________________________________________________
First Middle Last

Mailing Address______________________________________
Street City State Zip

Home Phone ____________Cell Phone ____________Work Phone ________

Employer____________________Occupation________________________

Date of Birth_________ SSN___________________

Gender: ☐ M ☐ F Race ______ Ethnicity______ Languages ____________

Referring Doctor_____________ Preferred Pharmacy___________________
Name, Street, Phone

## Responsible Party Information (If different than patient)

Guarantor's Full Name______________________ Relationship to Patient______

Mailing Address______________________________________

Home Phone ____________Cell Phone ___________Work Phone ________

Employer______________________________Occupation_____________

Date of Birth ____________ SSN_______________

## Spouse Information

Spouse's Name ________________________________________

Date of Birth _____________ SSN ______________ Cell Phone _________

Employer ___________________ Occupation __________ Work Phone_____

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## Primary Insurance Information

Name ______________________________________________

Address____________________________________________
Street City State Zip

Phone______________Policy#____________________Group#__________________

Policyholder's Full Name ___________________________SSN__________________

## Secondary Insurance Information

Name______________________________________________

Address____________________________________________
Street City State Zip
Phone______________Policy#____________________Group#__________________

Policyholder's Full Name ___________________________SSN__________________

## Emergency Contact Information

Name______________________________________________

Phone_____________________________________________
Home Cell Other

Relationship to patient_____________________________________

Address____________________________________________
Street City State Zip

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## Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Houston Rheumatology and Allergy Clinic's *Notice of Privacy Practices*, which explains how my medical information will be used and disclosed. I understand that this information can and will be used to:

- Conduct and direct my treatment among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations (e.g. quality assessments)

I understand that I may request, in writing, that this office restrict how my private information is used or disclosed. I also understand that the office is not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

I am entitled to request and receive a paper copy of the *Notice of Privacy Practices*.

______________________________________
Name of Patient

______________________________________ __________________
Signature of Patient or Patient's Parent/Guardian Date

## Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment directly to Houston Rheumatology and Allergy Clinic (Naureen Alim, MD, PLLC) for medical services rendered to myself and/or my dependents at this office. I understand that I am responsible for any amount not covered by insurance.

I further authorize Houston Rheumatology and Allergy Clinic to release any information necessary to process the claim and payment of benefits. I authorize the insurance company or health plan administrator to release all pertinent financial information concerning coverage and payments under my policy to Houston Rheumatology and Allergy Clinic (Naureen Alim, MD, PLLC).

A photocopy of my signature on this assignment is to be considered as valid as the original.

This assignment will remain in effect until revoked by me in writing.

______________________________________
Patient Name

______________________________________ __________________
Patient Signature or Responsible Party Signature Date

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**Authorization for Release of Diagnostic Reports and Electronic Information**

I authorize Dr. Naureen Alim and the staff of the Houston Rheumatology and Allergy Clinic to leave diagnostic test results pertaining to my medical care (or if patient is a minor, for my dependent/child's medical care) on my answering machine and/or voicemail.

*(Please choose one option below and sign next to the option you choose)*

_____ YES Signature:_______________________________Date:__________________________

_____ NO Signature:_______________________________Date:__________________________

I authorize Dr. Naureen Alim and the staff of the Houston Rheumatology and Allergy Clinic to provide me appointment reminders, and notification of the availability of diagnostic test results for myself (or if patient is a minor, for my dependent/child) by HRAC patient portal.

*(Please choose one option below and sign next to the option you choose)*

_____ YES Email Address: ________________________________________________________

Signature:_______________________________Date:__________________________

_____ NO Signature:_______________________________Date:__________________________

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## Financial Policy

Understanding medical care finances can be challenging, especially since an office visit may Involve multiple payers. In an effort to provide you with a full understanding of your financial responsibilities as an important aspect of your medical care, we have developed the following policies. Please feel free to ask any questions or discuss any concerns with us.

1. Full payment is due at the time of service.
2. Our office accepts cash, personal checks, and most major credit cards.
3. Our office has made arrangements with many insurance carriers to accept an assignment of benefits. In these instances, we will bill those insurance plans directly. You, however, are still required to pay your co-payment, co-insurance, insurance deductible, and/or fees for services "not covered" by your insurance plan. Payment will be collected at the time of service, or is due upon receipt of a statement from our office.
4. As a courtesy, we may obtain information regarding specific benefits covered and payable under your health insurance plan but it is your responsibility to be aware of the details of your health care coverage, since the benefit information provided to our office by your health insurance company may not be accurate.
5. Patients with an outstanding balance are required to pay their balance before an appointment will be scheduled.
6. There will be a $35.00 charge on returned checks and future payments will be required in the form of cash or credit card.
7. For services rendered to minor patients, we will expect payment from the adult accompanying the patient, and/or the patient's parent and/or guardian.
8. **No show policy**- Patients who fail to keep their appointments or cancel less then 24 hours notice more than once will be dismissed from the practice. If you do not keep an appointment, and **you fail to reschedule or cancel at least 24 hours prior** to your appointment, you may be subject to **a $35.00 cancellation fee**. **Appointments cancelled within the 24-hour period will be treated as a no show and the no show policy will apply**.
9. If you cancel or reschedule **2 consecutive times** then you will incur a **$35.00 fee**. If you fail to keep your 3rd appointment then you may be dismissed from the practice.
10. The office will charge a fee of $25.00 for forms filled out at the patient's request.

______________________________ ________________________
Patient Name Date

____________________________________________
Patient Signature or Responsible Party Signature

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**Acknowledgement of Financial Responsibility**

I have read, understand, and agree to the Houston Rheumatology and Allergy Clinic (HRAC) Financial Policy as outlined above. I have requested medical services from HRAC on behalf of myself and/or my dependent(s), and understand that by making this request I am financially responsible for any and all charges incurred.

I acknowledge that any benefit information obtained by HRAC on my behalf was qualified by the health insurance company with the following statement: 1) This is an estimate of the benefits provided under the insurance contract; 2) Any payment is subject to the coordination of benefits with any other insurance that may cover the services rendered and the coverage being in effect on the date of service; 3) Verification of eligibility or benefits is not a guarantee of coverage or payment and is subject to any policy provisions and exclusions that are in effect at the time services are rendered.

HRAC does not accept responsibility for collection of insurance proceeds or for negotiating settlement of disputed claims. If my insurance company does not pay the claim in full, I am responsible for payment of the balance including any finance charges or collection fees that may be included.

__________________________________ ____________________________
Patient Name Name of Responsible Party (Parent/Guardian)

__________________________________________________
Patient Signature or Responsible Party SignatureDate

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## General Consent for Evaluation and Treatment

I, ________________________________________, have requested to be evaluated and treated by the Houston Rheumatology and Allergy Clinic (HRAC). I understand that certain office procedures may be appropriate for my medical evaluation and treatment. These procedures may include, but are not limited to, the following:

*Allergy skin prick testing*
*Intra-dermal skin testing*
*Drug or Food Allergy Testing and/or Incremental Challenge Testing*
*Joint fluid aspiration and/or injection(s) with or without ultrasound guidance*
*Therapeutic medication injection(s)*

The general risks of the above stated procedures include: pain, damage to skin or adjacent tissues at the injection and/or skin testing site, allergic reaction, infection, localized swelling, redness, and itching, as well as the need for further medical treatment, and potential death in extreme circumstances.

Before any of these procedures are performed (if they are deemed appropriate for my care), the risks and benefits will again be reviewed with me verbally, and I will be given time to have all of my questions and/or concerns addressed regarding the specific procedure(s).
I can withdraw my consent for any diagnostic or treatment procedure at any time, verbally or in writing.

____________________________________ ____________________________

Patient Name Name of Responsible Party (Parent/Guardian)

____________________________________ ______________

Patient Signature or Responsible Party Signature Date

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# NEW PATIENT HEALTH HISTORY

In order to treat you safely and effectively, please answer the following questions. This is for our records only, and responses are confidential.

**Name**: ____________________ **Age**: ___ **DOB**: __/__/____ **Ht**:____ **Wt**:_____

**What is the reason for your visit?**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**How long has this been present?** __________________________________________

**Do you have any allergies to medications?** ☐ No ☐ Yes *(specify medications and reactions)*

______________________________________________________________________

**Medications** – attach separate sheet if necessary.
Please list ALL medications, non-prescription medications, supplements, herbals, birth-control pills etc. Please bring your medications with you to your appointments.

| Name | Dose/Frequency | Name | Dose/Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Past Medical and Family History** - Mark all that apply and please specify the condition:

| | Yourself | Blood relative | | Yourself | Blood relative |
|---|---|---|---|---|---|
| High blood pressure | ☐ | ☐ | Depression/Anxiety | ☐ | ☐ |
| High cholesterol | ☐ | ☐ | Osteoarthritis | ☐ | ☐ |
| Heart disease | ☐ | ☐ | Rheumatoid arthritis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Lupus | ☐ | ☐ |
| Heartburn (GERD) | ☐ | ☐ | Blood disorders | ☐ | ☐ |
| Sleep apnea | ☐ | ☐ | Clotting problems | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | Stroke | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Seizures | ☐ | ☐ |
| Lung Disease | ☐ | ☐ | Kidney disease | ☐ | ☐ |
| Cancer | ☐ | ☐ | Liver disease | ☐ | ☐ |
| Skin disease | ☐ | ☐ | Allergies | ☐ | ☐ |
| Thyroid disease | ☐ | ☐ | Eye disease | ☐ | ☐ |

Other: ______________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Past Surgical History** – mark all that apply and please indicate dates of surgeries:
☐ Tonsillectomy ☐ Hysterectomy ☐ Joint replacement ☐ Sinus surgery ☐ Cataract
☐ Cardiac stent/Cardiac bypass ☐ Other ________________________________

**Social History**:

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Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Occupation:______________________ Education level: __________________________
Do you smoke? ☐ Never ☐ Yes ☐ Quit (year) _______
Do you drink alcohol? ☐ No ☐ Yes (how many drinks per day)______________________
Do you exercise? ☐ No ☐ Yes (How often and what type?) _________________________

**Ob/Gyn History** *(for females only):*
Are you post-menopausal? ☐ Yes ☐ No
Number of pregnancies __________ Number of miscarriages (if any) __________

**Review of Systems**:
Please mark any symptoms present in the last 3 months.

Constitutional: ☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Fever ☐ Dizziness

Eyes: ☐ Change in vision ☐ Eye pain ☐ Eye redness ☐ Dry eyes ☐ Itchy eyes

E/N/T: ☐ Ear ringing ☐ Hoarseness ☐ Nose bleeds ☐ Post nasal drainage ☐ Hay fever ☐ Itchy throat ☐ Itchy ears ☐ Sinus congestion / pressure ☐Ulcers /sores in mouth

Heart: ☐ Chest pain ☐Palpitations ☐Leg swelling ☐ Fainting ☐ Sleeping on >2 pillows

Lungs: ☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Blood tinged sputum

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Black stools ☐ Heartburn ☐ History of liver disease or abnormal liver tests

Genitourinary: ☐ Painful urination ☐ Blood in urine ☐ Frequent urination ☐ Urine incontinence

Skin: ☐ Rash ☐ Hair loss ☐ Itching ☐ Problems going out in the sun ☐ Hives ☐ Nail changes ☐ Color changes of hands and feet in cold

Musculoskeletal: ☐ Joint pains ☐ Joint swelling ☐ Joint stiffness ☐ Joint redness ☐ Muscle aches ☐ Back pain

Psych: ☐ Anxiety ☐ Depression ☐ Sleep problems

Neuro: ☐ Seizures ☐ Vertigo ☐ Weakness ☐ Numbness ☐ Tingling

Endocrine: ☐Feeling too hot ☐ Feeling too cold ☐ Excessive thirst ☐ Enlarging hands or feet

Heme: ☐ Easy bruising ☐ Abnormal bleeding ☐ Abnormal lymph nodes ☐ History of transfusion