ADVANCED ALLERGY & ASTHMA ASSOCIATES

Swapnil Vaidya, MD PhD
Kellie Vaidya, MPH, PA-C
Dalia Galicia, MD
ALLERGY, ASTHMA & IMMUNOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____
Date of Birth: _____

I, acknowledge that Advanced Allergy & Asthma Associates has provided me a copy of their Notice of Privacy Practices, effective July 1, 2013 (Revised ~~6/16/2021~~ 3/7/2022). I have had the chance to review this Notice.

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Print Name Relationship to Patient

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of your Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: _____

_____ _____ _____
Staff Name Staff Signature Date

CIRCLE BELOW LOCATION:

9433 N. Beach St, Suite 111
Fort Worth, TX 76244
817-428-7000 (T) * 817-428-7006 (F)

540 E. Southlake Blvd, Suite 140
Southlake, TX 76092
817-410-2111 (T) * 817-410-2113 (F)

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_____ I hereby give consent for the patient named above to be treated by providers at Advanced Allergy & Asthma Associates.

_____ I acknowledge that Advanced Allergy & Asthma Associates will file insurance claims on my behalf and hereby authorize the release of any information required to process insurance claims and determine benefits. I authorize payment of benefits directly to Advanced Allergy & Asthma Associates for services rendered. I understand that I am financially responsible for all co-pays, deductibles, co-insurance, non-covered services and unpaid services. I understand that payments are due at the time of service.

_____ I understand that if I require a **referral authorization** from my insurance company then I am responsible for ensuring that the referral approval/authorization is on file with Advanced Allergy & Asthma Associates before services are rendered. I further understand that in order for continuity of care, I am also responsible for ensuring that there is an up-to-date referral on file AT ALL TIMES. Should a referral authorization/approval expire and in the event that my insurance company will not back date or pay for the services provided by Advanced Allergy & Asthma Associates after said expired referral then I understand that I will be financially responsible for all co-pays, deductibles, co-insurance, non-covered services and unpaid services. I understand that payments are due at the time of service.

_____ I understand that if a minor patient, a parent or legal guardian must be present in the building at all times in order for minor to receive treatment, testing, or injections. (Authorized individuals must be listed on attached Permission to Treat a Minor acknowledgement form)

_____ I understand that delinquent accounts will be referred to outside collection agencies and subject to interest and additional fees.

_____ All medical records are the property of Advanced Allergy& Asthma Associates. Any copies of medical records may be subject to a fee.

_____ I authorize Advanced Allergy & Asthma Associates to call or mail me with communication regarding my healthcare. I understand the privacy risks of phone calls and mail.

_____ I have received and reviewed the Office Policies of Advanced Allergy & Asthma Associates.

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Print Name Relationship to patient