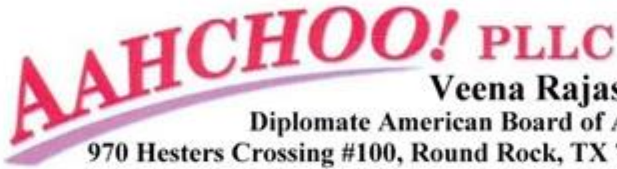


Veena Rajashekhar, MD
Diplomate American Board of Allergy and Immunology, FAAAAI
970 Hesters Crossing #100, Round Rock, TX 78681 Ph (512)248-8864 / Fax (512)906-2751

GUARANTOR INSURANCE INFORMATION and CLAIMS FILING AUTHORIZATION

PRIMARY POLICY

INS. COMP NAME: ____________________ADDRESS:____

POLICY HOLDER (NAME ON CARD): ____________________________RELATIONSHIP TO PATIENT:________________

POLICY #__________________GROUP #__________________

POLICY HOLDER SOCIAL SECURITY/ DOB#____

INS. PHONE NUMBER / WEBSITE: ____

SECONDARY POLICY

INS. COMP NAME: ____________________ADDRESS:____

POLICY HOLDER (NAME ON CARD): ____________________________RELATIONSHIP TO PATIENT:________________

POLICY #_______________GROUP #_____________POLICY HOLDER SOCIAL SECURITY#____________________

INS. PHONE NUMBER / WEBSITE: ____

I, the undersigned, certify that I (or my dependent) have the above insurance coverage and assign directly to AAHCHOO, PLLC or Veena Rajashekhar, MD all insurance benefits. I understand that I am financially responsible for all charges incurred that are not paid by the insurance, excluding contract allowance adjustments. I agree to pay my cost share or deductible at the time services are rendered. If there is any balance left once the insurance has paid its portion I will pay the balance within 30 days from the date of service.
Agreement to pay: the undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Texas, or any other state.

PATIENT'S NAME: ____

PATIENT/POLICY HOLDER SIGNATURE: ________________________________ DATE: ___________
(In lieu of HCFA form 1200, this will serve as signature on file)

- -

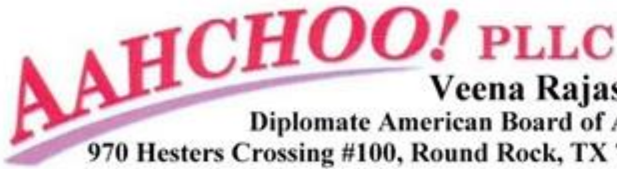
(FOR OFFICE USE ONLY)

INSURANCE BENEFITS

$_____ OFFICE VISIT COPAY. ALLERGY TESTING AND TREATMENT IS SUBJECT TO THE $__________ MAJOR MEDICAL DEDUCTIBLE, THEN PAYABLE AT _____% UCR, AND THE PATIENT IS RESPONSIBLE FOR THE REMAINING _____%. DEDUCTIBLE MET AS OF TODAY'S DATE: $__________ NOTES: ________________________________

SIGNATURE: ____

EXPLAINED BY: (STAFF INITIALS) _________ DATE: ________________



AAHCHOO, PLLC

1. CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION and

2. RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of consent: By signing this form, you consent to our use and disclosure of your protected health information **(PHI)** to carry out treatment, payment activities, and healthcare operations.

Notice of privacy practices: Our office promises not to disclose your **(PHI)** outside of this institution without your specific authorization. Our office complies with HIPAA and all federal and state laws regarding the privacy of your information. A copy of our Notice of Privacy Practices is available to you at any time in our office.

You may refuse to sign this form.

Patient Name (Print)____

Guardian Name (Print)____

Patient/Guardian Signature ______________________________ Date:__________________

Please name any additional person(s) who are authorized to access your **(PHI)** _____________

____

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but were unable to for the following reason:

__Individual refused to sign

__Communications barrier prohibited obtaining the acknowledgment

__An emergency situation

__Other:____

Staff signature: ______________________ Date: ____________