Allergy & Asthma Clinic of San Antonio

Adult & Pediatric

www.allergyasthmasa.com

OFFICE POLICIES

Dr. Miguel J. Martinez Jr. and the staff of the Allergy & Asthma Clinic of San Antonio welcome you to our practice. To best serve our patients, we have established the following office policies.

We appreciate the opportunity to work with you.

Payments: Our contract with insurance companies and health plans require that we collect all co-payments and deductibles amounts at the time of service. We accept cash, and major credit cards. If payment if not made at the time of service, an administrative fee of $10.00 will be assessed to you. This fee will not be billed to your insurance.

Assignments of benefits: We accept medical insurances and make prior arrangements to accept assignment of benefits. All insurances are not equal and provide different coverage for our services. We make every effort to have this information available for you prior to your appointment. Please remember that you have the contract with your insurance company, not our office. In the event that you insurance plan does not cover a service, you will be billed. If your insurance does not pay the office within 90 days of service, you will be held responsible for the balance.

Referrals: If your policy requires a written authorization you are responsible for obtaining it. As a courtesy to our established patients, we can request the follow-up referral in advance. Keep your appointments with you PCP (Primary Care Physician), to ensure that your visit is pre-approved, and to avoid extra charges to your account. Without a referral you are financially responsible for costs relating to the visit, including allergy shots, procedures and treatments.

Change of Information: Please provide us with any changes on your information, including both personal and insurance information, as soon as possible. Insurance information is required before every visit and it needs to be verified before you see your physician or receive services in our office.

Missed Appointments, "No Show" and Cancellations: We have a 24-hour cancellation policy. If an appointment is missed or cancelled with less than 24 hours' notice, a fee of $50.00 will be assessed to your account. We require that you pay this fee before your next appointment and before requesting refills of prescription medications. Your insurance company will *not* be billed for fees associated with missed appointment or last minute cancellations.

After Hours Care: Your physician has coverage during the nights and weekends. This service should be reserved for urgent problems that cannot wait until the next business day. If you have a life-threatening emergency, please call 911.

Prescription refills: Prescriptions are generally written in a quantity to last until the next appointment. Prior to your regular appointment, look over your medications, to determine if you will need request any prescriptions. It is essential to request prescriptions during your regular office visit. Please contact your pharmacy so they may request approval for the refill. Allow up to three business days for the prescription refill to be approved.

Medical Records and Forms Requests: All requested medical records have a fee as follows: the first 20 pages are a $50.00 charge and $1.00 per every extra page, plus mailing cost. We will send the copies when the payment is received.

If the medical record is requested by another medical provider, we will send the record without any charges.

All other forms, such as FMLA or disability forms, have a fee of $50.00, payable at the time of the request.

Waiting Time and Waiting Areas: We are a family-oriented practice and understand that sometimes you may need to bring your children to your visits. We generally only have accommodations for the patient and one additional person. An exception is made for children under 18 years old, which may be accompanied by both parents.

Authorization for use of e-mail/ fax communication: In order to better serve our patients, we may communicate with patients or their representatives via e-mail or fax. The purpose for the use of e-mail or fax may include, but is not limited to, the following: FMLA paperwork, school or work excuses, test results, medical statements, appointments and insurance, legal information, at the patients' request.

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SIGNATURE PAGE

Patient Name: ____ Date of Birth:__________________

Address: ____ Social Security #: ______- ____-______

____ Phone Number: _____________________

Email Address: ____

Please complete each of the following statements.

If not complete, the information will not be released thru e-mail or fax.

I ☐do ☐do not want HIV/AIDS information released under this authorization.

I ☐do ☐do not want mental health information released under this authorization.

I ☐do ☐do not want drug/alcohol abuse treatment information released under this authorization.

I ☐do ☐do not want developmental disability treatment information release under this authorization.

Please initial each of the following:

_____ I have been informed of the risk and procedures involved when using e-mail or fax. I agree to the terms listed on this form and hereby voluntarily request, consent to and authorize the use of e-mail and fax as one form of communication with my physician, and his associates, staff and other health care provider.

_____ I will use e-mail/fax for non-emergency purposes.

_____ I understand that all medication refills will be sent through e-mail or faxes to the pharmacy of my choice.

_____ I have received a copy of the office policies.

_____ I understand that the email/fax communications from Allergy and Asthma Clinic of San Antonio are not encrypted and that the security of such e-mail and faxes cannot be guaranteed.

_____ I understand that all e-mail and faxes will be in my permanent record.

_____ I agree to inform the office in writing if my e-mail or fax changes

_____ Notice of Privacy Practices (HIPPA): *I have reviewed the copy of the Allergy and Asthma Clinic of San Antonio HIPPA policies. I, the guarantor of payment and responsible party, agree to all the policies to the terms regarding treatment, payment and responsibilities.*

____ _______________

Signature of Patient/Patient Representative* Date

____

Printed Name of Patient/Patient Representative

____

Signature of Witness or Employee

**If signed by other than patient, state relationship*: ☐ Parent ☐ Guardian ☐Legal Representative

☐ Other:___________________________________