



Advanced Allergy, Asthma,
& Immunology Center

PATRICIA GOMEZ DINGER, D.O.

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname/AKA
Date of Birth	Social Security Number	Gender	Male Female
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Language other than English	
Race (Optional)	<input type="checkbox"/> Black - Non Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White - Non Hispanic <input type="checkbox"/> Other		
Home Address	Apt #	City	State Zip Code
Home Phone	Work Phone	Other Phone Cell Pager Fax	
Email Address			

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician Referring Physician

How did you
hear about us?

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient	(If self, skip to Emergency Contact)	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	
Home Address	Apt #	City State Zip Code
Home Phone	Work Phone	Other Phone Cell Pager Fax

EMERGENCY CONTACT INFORMATION

Last Name	First Name	Relationship to Patient
Address	Apt #	City State Zip Code
Home Phone	Work Phone	Other Phone Cell Pager Fax

INSURANCE INFORMATION

Primary Insurance	ID Number	Group Number	Telephone Number
Secondary Insurance	ID Number	Group Number	Telephone Number
Insured Member	Social Security Number	Date of Birth	ID Number

540 Madison Oak Drive, Suite 210/220 • San Antonio, Texas 78258 • 210-499-4824 • Fax: 210-499-4825

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

I, the undersigned, authorize payment of medical benefits to Advanced Allergy, Asthma, & Immunology Center, PA for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Advanced Allergy, Asthma, & Immunology Center, PA to release to my insurance company, referring physician and other consultants on my case information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date _____ Signed _____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Allergy, Asthma, & Immunology Center, PA for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Date _____ Signed _____

Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Advanced Allergy, Asthma, & Immunology Center, PA.

Print Patient Name _____ Date _____

Patient Signature _____

OFFICE POLICIES

SERVICES PROVIDED

Advanced Allergy, Asthma, and Immunology Center, PA has temporarily partnered with Alamo Asthma & Allergy Associates. We are a subspecialty clinic providing medical consultations. Our goal is to thoroughly evaluate your allergy, asthma, and immunology related problems and provide our recommendations to you and your primary care physician. Following your evaluation, you will be provided with a treatment plan which typically addresses anticipated disease flares. If your medical problems are not responding to our treatment, please contact us as soon as possible.

The partnership that we will establish with your primary care physician is key to providing you with optimal medical care. All patients seen at our office must have a primary care physician to provide them with the services not available at our office. A primary care physician can perform your needed routine health maintenance monitoring and we also expect them to provide for all of your urgent care needs. When our office is closed, please address all medically related issues to your PCP. If you do not have a primary care physician, please select one from your insurance provider list. We will forward a copy of our evaluation summary and any lab or testing reports to your PCP after each visit. If you have an emergency problem, you should call 911 or go to the nearest emergency room. Do not waste time attempting to contact a physician by phone. Severe asthma exacerbations or allergic reactions should always be seen in an emergency room and not in the physician's office.

APPOINTMENT SCHEDULING

Appointments will be made by phone during office business hours only. We will accept "walk-ins" for urgent care issues; however, because we are working you in, please be aware that you may have to wait so that patients with scheduled appointment are seen in a timely manner. We request that you arrive 15 minutes before your scheduled appointment so that you can complete the required paperwork. Arriving on time will greatly affect your satisfaction with our services and will prevent other patients from being inconvenienced. Our ultimate goal is to offer each of our patient's quality medical care in a timely manner.

APPOINTMENT CANCELLATIONS

When you are scheduled for an appointment, that time slot is made unavailable to any other person. If you do not show up as planned, we have lost the opportunity to provide our services to another patient. We ask that you cancel any appointment at least 24 hours in advance. We understand that occasionally appointments will be missed due to circumstances beyond your control; however we ask that you please try to notify us in advance. An appointment is not necessary to receive allergy shots at our clinic. All shots will be administered for walk-ins on a first come first served basis.

PRESCRIPTION REFILLS

By Texas Law, you must have been seen by your doctor within one year to obtain refills. For example, if you were seen 6 months ago and call for refills, we will provide you with an additional 6 moth supply and you will be expected to schedule an appointment within

6 months. Refills will be called or faxed to the pharmacy on the day requested typically after all clinic patients have been seen. Please try to call for refills during normal business hours and before you run out.

PHONE CALLS TO SPEAK WITH YOUR DOCTOR

In order to avoid delays in scheduled patient care, phone calls will typically be returned at the end of the day after all clinic patients have been seen or if there is a break in the schedule. When you leave a message, please provide phone number where you can be reached at the time you call and any other number where you may be reached that day. Please do not expect your doctor to treat a NEW medical problem over the phone. It is not possible for us to thoroughly evaluate you without the ability to perform a physical exam.

FINANCIAL POLICY

Dr. Patricia Gomez Dinger has temporarily partnered with Dr.'s Michael and Adrienne Vaughn of Alamo Asthma & Allergy Associates in order to provide you with the least amount of disruption to your allergy medical care during this transitional process. If a referral was required by your primary care physician, you will need to request from your provider an updated referral to Alamo Asthma & Allergy Associates. Nothing else will change, you will continue to be seen by Dr. Gomez Dinger at this location. If a referral was not necessary then you do not need to do anything more. Alamo Asthma & Allergy has contracted with most insurance plans to provide medical services at a discount. We will offer the same discounts to private pay clients. We will accept personal checks, debit cards, MasterCard, and Visa. A payment for your first office visit will be required at the time of service including all co-pay, deductible, and non-covered services. Any NEW patient seen or treated in our office without prior authorization (if required by your insurance) will be responsible for the full charge of the visit. It is the patient's responsibility to obtain authorization from their primary care physician prior to calling for an appointment. It is always to your advantage to discuss the covered benefits with your insurance company prior to your arrival. At your request we will provide you with an estimate of anticipated charges before any testing is done. If you have a large deductible that has not been met for the year, it may be wise to consider taking advantage of our discount of 50% off our usual charges offered for cash payments for those who are uninsured.

RADIOLOGY & LABORATORY SERVICES

If your insurance company has contracted with any specific lab or x-ray service facility, please notify our staff of this requirement. We do not draw blood or perform x-rays at our office.

(It is our sincere hope that this policy will be helpful and reduce any misunderstanding concerning the services provided by Dr Gomez Dinger and Alamo Asthma & Allergy)

I have read and understand the above information, including the need for a PCP to provide for my health maintenance and urgent care medical needs.

Patient Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this

TREATMENT

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

PAYMENT

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. This form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO need to approve payment to us.

HEALTH CARE OPERATIONS

We are permitted to use or disclose your medical information for the purpose of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only best health care is provided by this practice.

DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization, or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

ADDITIONAL USES OR DISCLOSURES

- Public Health, Abuse or Neglect and Health Oversight
- Legal Proceedings and Law Enforcement
- Military, National Security and Intelligence Activities, Protection of The President
- Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

WORKERS' COMPENSATION

We may disclose your medical information as required by the Texas workers' compensation law.

INMATES

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

REQUIRED BY LAW

We may release your medical information where the disclosure is required by law.

YOUR RIGHTS UNDER FEDERAL PRIVACY REGULATIONS

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

REQUESTED RESTRICTIONS

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing:

- (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below. You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

RECEIVING CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

INSPECTION AND COPIES OF PROTECTED HEALTH INFORMATION

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that request for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes
- Includes the identity of a person who provided the information promise of confidentiality
- Is subject to the Clinical Laboratory Improvements Amendments of 1988
- Has been compiled in anticipation of litigation

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review. Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready, or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

AMENDMENT OF MEDICAL INFORMATION

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Was not created by this practice or the physicians here in this practice
- Is not part of the Designated Record Set
- Is not available for inspection because of an appropriate denial
- If the information is accurate and complete

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

ACCOUNTING OF CERTAIN DISCLOSURES

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting of disclosure to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND OTHER HEALTH-RELATED BENEFITS

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

COMPLAINTS

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

HIPAA Complaint
7500 Security Blvd, CS24-04
Baltimore, MD 21244

QUESTIONS AND CONTACT PERSON FOR REQUESTS

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Patricia Gomez Dinger, D.O.
540 Madison Oak Drive, Suite 210/220 • San
Antonio, Texas 78258
Phone 210-499-4824 • Fax: 210-499-4825

This notice is effective on the following date: April 14, 2003. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If, or when we change our notice, we will post the new notice in the office where it can be seen.