ALLERGYSA.COM
Allergy, Asthma & Immunology
ASSOCIATES OF SOUTH TEXAS

PRACTICE POLICY ACKNOWLEDGEMENT

Allergy, Asthma and Immunology Associates would like to welcome you to our office. We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read and sign at the bottom. A copy will be given for your records.

1. **PAYMENTS.** All applicable fees, deductibles, coinsurance or co-pays must be paid at the time of your appointment. We accept cash, checks, Visa, MasterCard or Discover.
2. **CANCELLATIONS.** If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment. Otherwise, a $50.00 fee will apply.
3. **APPOINTMENT TIME.** We ask that our patients arrive on time for their appointments. This will facilitate our ability to see you as scheduled. In an effort to serve all our patients well, patients arriving 15 minutes past their appointment time may be rescheduled.
4. **REFERRALS.** If your policy requires written authorization from your primary care physician (PCP), you are responsible for obtaining it. We will request authorization in advance for established patients only. This is done as a courtesy for our patients. However, we cannot guarantee authorization will be granted. Please keep in contact with your primary care physician to ensure your visit is pre-approved to avoid having to make payment in full.
5. **CHANGE OF INFORMATION.** Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a *New Patient Information Form* and may not be changed over the telephone.
6. **MEDICATION REFILL REQUESTS.** Please contact your pharmacy first. They will call our office for authorization of refills.
7. **AFTER HOURS CARE.** If you must speak with a provider, please dial the main office number at **(210) 616-0882** and leave a message with the answering service. The provider on-call will return your phone call as soon as possible. In a life-threatening emergency, call 9-1-1.
8. **MEDICAL RECORD COPY REQUESTS.** Requests for copies of your medical records must be made in writing on a form provided by our offices. Our office will respond within 15 business days to properly complete written request. **FEES:** As per the rules adopted by the Texas State Board of Medical Examiners, our office will charge for copying records.
9. **COMPLETION OF FORMS.** Our office will respond to requests for the completion of FMLA and Disability forms following the receipt of a $25.00 fee. Please allow five working days for completion.
10. **RESEARCH:** I authorize Allergy, Asthma & Immunology Associates of South Texas to use and disclose my protected health information to Allergy, Asthma Research Center or any other affiliated organizations for the purpose of gathering information for research studies, and that I may be considered for possible participation in research trials.
11. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

    I, _____ have received or reviewed a copy of Allergy, Asthma and Immunology Associates of South Texas Notice of Privacy Practices.

I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and responsibilities.

_____ _____

Signature Date

White = Patient **Yellow = Patient File**

Main Office:
Medical Center
2414 Babcock Rd. Ste 109
San Antonio, TX 78229

Southside:
SW Medical Bldg.
7500 Barlite Blvd. Ste 106
San Antonio, TX 78224

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