Harker Heights Allergy
2025 Memory Lane #400A
Harker Heights, Texas 76548
Phone: 254-432-5945 | Fax: 254-432-5952

HARKER HEIGHTS ALLERGY
ALLERGY | ASTHMA | IMMUNOLOGY

Temple Allergy Clinic
2027 S 61st Street #108
Temple, Texas 76504
Phone: 254-773-8916 | Fax: 254-228-5574

Patient Information			
Patient's Last Name: First: MI:			Social Security Number:
Birth Date:	Age:	Sex:	Ethnicity:
Street Address:			
City:	State:	ZIP Code:	
Home Phone:	Cell Phone:	Work Phone:	
E-Mail Address:	Employer or Student Status:		
Referring Physician Name:	Primary Care Physician Name:		

Emergency Contact		
Emergency Contact Name:	Relationship:	Phone:

Primary Insurance		Secondary Insurance	
Carrier:	Cardholder's Name:	Carrier:	Cardholder's Name:
Relationship to Patient:	Cardholder's Birth Date:	Relationship to Patient:	Cardholder's Birth Date:
Cardholder's Social Security Number:		Cardholder's Social Security Number:	
Identification Number:		Identification Number:	

Pharmacy Information		
Preferred Pharmacy Name:	Phone:	Address or Intersection:

Medical Release		
I hereby authorize the release of my medical records to the following individuals:		
Name:	Relationship:	Date:
Name:	Relationship:	Date:

Office visit co-pays or deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage. My signature below confirms that the information provided is accurate and complete to the best of my knowledge. I consent to the performance of diagnostic procedures, examinations, and rendering of treatment that the medical provider and designated medical staff as it is deemed necessary in the medical provider's best judgment.

Signature of Patient or Responsible Party:	Date:

How did you hear about us? _____

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Financial Responsibility Policy

1. I understand that I, _____, am responsible for confirming my medical benefits (or those of my dependents) with my insurance group and that I am expected to have this information at the time of my visit.
   Patient Initials_____
2. I understand that Harker Heights Allergy Asthma & Immunology cannot guarantee that the information received from my insurance company is accurate. I am fully responsible for all charges deemed my responsibility to my account. **Patient Initials**_____
3. I understand that Harker Heights Allergy Asthma & Immunology will bill my insurance company according to all Federal rules and regulations and provide my insurance company with copies of all appropriate and required information. Harker Heights Allergy Asthma & Immunology is not responsible for lost claims. **Patient Initials**_____
4. I understand that Harker Heights Allergy Asthma & Immunology will make any reasonable effort to assist me in resolving any disputed claims or payment for such claims; however, the contractual relationship for payment of such claims lies solely between myself and my insurance carrier and I am ultimately responsible for all services provided.
   Patient Initials_____
5. I understand that if my plan is out-of-network or services are determined "non-covered" due to plan provisions, preexisting conditions, or riders on my policy, I am fully responsible for services incurred. **Patient Initials**_____
6. I understand that if I elect to pay privately at my first visit due to lack of insurance, lack of coverage, failure to provide my insurance card at the time of service, or failure to verify coverage, Harker Heights Allergy Asthma & Immunology will not retroactively submit claims or change account responsibility. **Patient Initials**_____
7. I understand that it is my responsibility to provide accurate and updated insurance information to Harker Heights Allergy Asthma & Immunology at every visit, if applicable.
   Patient Initials_____
8. I understand it is my responsibility to be involved proactively in obtaining required referrals that may be required to obtain care, depending on my insurance policy.
   Patient Initials_____

Assignment of Benefits

1. I understand and agree that I am financially responsible and must pay all deductibles, co-payments, and amounts disputed by my insurance carrier for healthcare services rendered by Harker Heights Allergy Asthma & Immunology to me or my dependent(s).
   Patient Initials_____

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2. I understand and agree that Harker Heights Allergy Asthma & Immunology may utilize any legal means to collect payment for any healthcare services rendered to me or my dependent(s). In the event that legal action is taken, in order to enforce the terms and conditions of this agreement, the prevailing party shall be entitled to recovery of all attorney and or collection fees and costs. **Patient Initials**_____

No-show/Late Fee and Card-On-File Policy

For all appointments, we require a 24 hours' notice in the event of cancellation or rescheduling. If full notice is not provided, we will bill **a $35 no show fee** for medical appointments. Additionally, if you are more than 15 minutes late to your appointment and there is insufficient time to perform the appointment, the appointment may be cancelled or rescheduled and you will be subject to a **$35 fee**. **Patient Initials**_____

Our policy is to have an active credit card on file to charge immediately for services, past due balances, payment plans, and no-show fees. **Patient Initials**_____

Please indicate a maximum amount per month you authorize your card to be ran for, if you do not have an active payment plan established and have a patient balance due: $_____. *(Minimum amount of $25 is required)* **Patient Initials**_____

Type of card: Visa Mastercard Discover American Express Other:_____

Card Number: _____ **Zip Code:**_____

Security Code:_____ **Expiration Date:**_____

Name on Card:_____

By signing below, you acknowledge that you have read, understand, and agree to our financial policy, assignment of benefits, no-show/late fee policy, and card on file policy. You authorize Harker Heights Allergy Asthma & Immunology to use the information above for all payments. You also understand that HIPAA privacy laws prevent Harker Heights Allergy Asthma & Immunology staff from using the above information for any other purposes.

Patient's full name: _____

Signature:_____Date:_____

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Patient Authorization for E-Mail and SMS Text Communication

Harker Heights Allergy, Asthma & Immunology will use e-mail and SMS text messages for appointment reminders and emergency purposes only.

E-mail communications from Harker Heights Allergy, Asthma & Immunology are on an un-encrypted server and the security of such e-mails cannot be guaranteed. Furthermore, Harker Heights Allergy, Asthma & Immunology is not responsible for e-mails reaching any unintended recipients.

I will inform Harker Heights Allergy, Asthma & Immunology of any changes of e-mail address or phone number.

I understand that I may be charged for calls or SMS texts by my wireless carrier.

My signature below acknowledges that I have read Harker Heights Allergy, Asthma & Immunology's Authorization for E-mail and SMS Text Communication and consent to receiving such communication.

Patient Name:	Date of Birth:
Signature of Patient or Responsible Party:	Date: