

Children's Asthma, Sleep, and Pulmonary Institute
5282 Medical Drive, Suite 120
San Antonio, TX 78229
Phone: 210-615-3700 Fax: 210-615-3701

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Name of Patient

Signature of Patient or Patient's Parent/Guardian

Date

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Authorization for Release of Information (page 1 of 2)

I, (patient name/parent or legal guardian) _____, authorize (name and address of your referring physician/primary care physician or other third party):

to release all medical information (unless otherwise specified below) including, but not limited to:

- 1) Information on medical conditions, evaluations, lab reports, and treatments
- 2) psychiatric conditions, alcohol, and drug abuse
- 3) Communicable diseases
- 4) HIV

to the Children's Asthma, Sleep, and Pulmonary Institute (CASPI). Similarly, I authorize CASPI to disclose my protected health information to my referring physician, family physician, and other person/entity disclosed below.

RESTRICTIONS FOR RELEASE OF MEDICAL INFORMATION: (CIRCLE) YES (LIST BELOW) OR NO

_____.

AUTHORIZATION TO DISCLOSE TO OTHER INDIVIDUAL(S) OR ENTITY LISTED BELOW (IF APPLICABLE):

_____.

The reason for disclosure and use of my protected health information is to provide medical care.
LIST OTHER REASONS FOR DISCLOSURE:

_____.

I agree that these provisions will remain in effect until I provide written revocation to CASPI.

I understand that a revocation will not be effective if the practice has relied on the authorization in making use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand I have the right to refuse to sign this authorization.

Patient/Responsible Party Signature

Date

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Authorization for Release of Information (page 2 of 2)

Please mail health records and information to:
Children's Asthma, Sleep, and Pulmonary Institute
Attention: Medical Records
5282 Medical Drive, Suite 120
San Antonio, TX 78229

Or you may fax to:
210-615-3701

Patient's Name: _____

Date of Birth: _____

Patient's Address: _____

Signature of Patient/Patient's Parent/Legal Guardian _____

Date: _____

Patient Financial Policy

Understanding medical care finances can be challenging, especially since an office visit may involve multiple payers (such as the patient and one or more insurance companies). In an effort to provide you with a full understanding of your financial responsibilities, as an important aspect of your medical care, we have developed the following policies. Please feel free to ask any questions or discuss any concerns with our billing manager.

1. Full payment is due at the time of service, unless other arrangements have been made in advance by you or your health care insurance carrier.
2. Our office accepts cash, personal checks, and credit cards (Visa, MasterCard, and Discover).
3. Our office has made prior arrangements with many insurance carriers to accept an assignment of benefits. In these instances, we will bill those insurance plans directly. You, however, are still required to pay your co-payment, co-insurance, insurance deductible, and/or fees acquired for services "not covered" by your insurance plan. Payment may be collected at the time of service, or will be due upon a statement from our office.
4. We require that the co-payment be collected at the time of service. If you are not able to make your co-payment, you may be subject to a \$10.00 delayed payment fee.
5. All services provided in the hospital will be billed to your health insurance carrier. Any balance due is your responsibility, and is due upon receipt of a statement from our office.
6. There will be a \$35.00 charge on all returned checks. Repeat offenders will be reported to the appropriate authority.
7. For all services rendered to minor patients, we will expect payment from the adult accompanying the patient, and/or the patient's parent and/or guardian.
8. If you do not keep an appointment, and you fail to call to reschedule or cancel within 24 hours of your appointment, you may be subject to a \$35.00 cancellation fee.

Patient Name

Patient Signature or Responsible Party Signature

Date

Assignment of Benefits Form

Financial Responsibility

I have read, understand, and agree to the Children's Asthma, Sleep, and Pulmonary Institute's (CASPI) Financial Policy. I understand that charges not covered by my insurance company, as well as my applicable co-payments, co-insurance, and deductibles are my responsibilities. All professional services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments if arrangements have been made in advance between CASPI and your insurance carrier(s).

I have requested medical services from CASPI on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary for CASPI to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to CASPI for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize CASPI to: 1) Release any information necessary to insurance carriers, Medicare, or other third party payers, regarding my illness, treatments, and financial information as it pertains to my health care; 2) To process insurance claims generated in the course of examination or treatment; and 3) To allow photocopy of my signature to be used to process insurance claims.

I authorize CASPI to contact my insurance company and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to CASPI (Kelly J. Smith, MD, PA). This order will remain in effect until revoked by me in writing.

_____	_____
Patient Name	Responsible Party (Parent/Guardian)
_____	_____
Signature of Patient or Responsible Party	Date

Witness: _____

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Patient Insurance Coverage Form

As a courtesy to me, Children's Asthma, Sleep, and Pulmonary Institute (CASPI) has obtained information regarding specific benefits covered and payable under my health insurance plan from a representative of my health insurance company and has explained those benefits to me. I understand that CASPI has acted in good faith in this effort and that the benefit information provided to CASPI by my health insurance company may not be accurate

I acknowledge that the benefit information obtained by CASPI on my behalf was qualified by a representative of my health insurance company with the following statement: 1) This is an estimate of the benefits provided under that patient's insurance contract; 2) Any payment is subject to the coordination of benefits with any other insurance that may cover the services rendered and the coverage being in effect on the date of service; 3) Verification of eligibility or benefits is not a guarantee of coverage or payment and is subject to any policy provisions and exclusions that are in effect at the time services are rendered.

Patient Name

Responsible Party (Parent/Guardian)

Signature of Patient or Responsible Party

Date