ARACELI ELIZALDE, MD
Board Certified Adult & Pediatric Allergist and Immunologist

PRACTICE POLICY AND FINANCIAL AGREEMENT

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 carefully and sign at the bottom.

1. **CONSENT TO TREAT**. I consent to any treatment, test or procedure ordered by and given under the supervision of Dr. Elizalde. I acknowledge that no guarantee has been made as to the results of the medical treatment, hereby authorized
2. **PAYMENTS.** Allergy & Asthma Texas Health files insurance claims for insurance plans with which we participate. We accept payment for covered services from these insurance plans in accordance with our contract. **Our patients are responsible for applicable co-insurance and deductible amounts. Our patients are also responsible for any and all payments for services that are no covered by insurance. All applicable fees, deductibles, coinsurance or co-pays must be paid at the time of your appointment.** We accept cash and credit card.
3. **DIAGNOSTIC TESTING. Allergy skin testing, breathing testing and other testing, if recommended by the physician, will be an additional charge separate from your visit**. Ultimately it is your responsibility to know the benefits of your insurance plan. We are happy to provide you with an estimate of your total out of pocket cost.
4. **CANCELLATIONS**. **If you need to cancel your appointment, be sure to call us at least 48 hours before your scheduled appointment**. **You will be required to pay a $50.00 deposit fee for rescheduling an appointment with us more than two times.**
5. **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**.
6. **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.
7. **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.
8. **MEDICATION REFILL REQUESTS**. Please contact your pharmacy first. They will call our office for authorization of refills. **Refill request will be handled during office hours**.
9. **AFTER HOURS CARE**. If you must speak with Dr. Elizalde, please dial the main office number at (210) 899-6856 and leave a message with the answering service. She will return your phone call as soon as possible. In a life-threatening emergency, call 9-1-1.
10. **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.
11. **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.
12. **LOST FORMS.** Our office will respond to requests to replace lost forms/lab orders following the receipt of a $10.00 fee.
13. **LAB RESULTS. If coming to the office to review lab results, please call our office 1-2 days prior to your appointment to ensure the lab has sent us your results.**
14. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**:

I, ______________________________ have received or reviewed a copy Allergy & Asthma Texas Health 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. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company; I permit a copy of this authorization to be used in place of the original.

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Responsible Party Name (please print and sign) Date

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