

MEDICAID AGREEMENT

I certify that _____ only has coverage through Texas
PATIENT NAME

Medicaid. _____ does not have coverage through any type of
PATIENT NAME

Private Insurance.

Current coverage under Texas Medicaid includes:

- Aetna Medicaid
- Amerigroup
- Cigna Health Spring
- Cook Children's STAR/CHIP
- Traditional Medicaid
- Molina
- Superior

I understand it is my responsibility to inform Moonhee Lee, MD and Medicaid if I should ever have coverage with a Private Insurance. If Medicaid rejects any medical claims from this office due to having other health insurance, I understand that it is my responsibility to correct the error. Any unresolved coordination of benefits issues will become my liability.

_____ I have fully read and understand the above text.

INITIAL

Patient Name: _____

Signature (or Legal Guardian): _____

Date: _____

MOONHEE LEE, M.D.

DIPLOMATE

- AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY
- AMERICAN BOARD OF INTERNAL MEDICINE

Consent Form for Treatment of a Minor

Name of Child: _____ **DOB:** _____

This consent form is to authorize someone over the age of 18 other than the parent or legal guardian to accompany the child to their office visit, walk-in allergy injection and/or Rush treatment.

Please initial next to each one after you have carefully read it:

____ I understand that there must be a parent, legal guardian or someone over the age of 18 present with my child at all time.

____ I understand that my child will not be seen or treated if he/she is left alone at any time while he/she is there.

____ I understand that I am fully responsible for my child and the consequences that can occur if he/she is left without supervision.

____ I understand that this form will remain in effect until I decide to revoke by filling out a new consent form, which can be provided by the front desk receptionist.

I acknowledge that in order for Dr. Lee and his staff to see and treat my child they must be accompanied by an adult at all times. All questions that I have concerning the treatment of a minor have been answered to my satisfaction. I am aware that I have the right to revoke my consent for any reason and at any time upon written notice of this desire. I hereby state that I have read and understand this consent and I have affixed my signature attesting to the same.

Initial one:

____ I authorize someone else over the age of 18 to bring my child to his/her appointments.

____ I **do not authorize** someone else to bring my child to his/her appointments and I understand that a parent/ legal guardian must be present.

Printed name of Parent/ Legal Guardian: _____

Signature: _____ **Date signed:** _____

ALLERGY AND ASTHMA CENTER OF SOUTHWEST ARLINGTON

MOONHEE LEE, M.D.

DIPLOMATE

- AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY
- AMERICAN BOARD OF INTERNAL MEDICINE

PLEASE READ THIS CAREFULLY BEFORE SIGNING

Every effort is made to obtain detailed and accurate insurance benefit information on each individual patient that comes to our office. Unfortunately, the insurance companies do not guarantee that the coverage and benefit information they give is accurate and state this at the beginning of every call we make to them. Although rare, errors are occasionally made by them. We cannot be responsible for this and the balance of whatever the insurance company says you owe will be due from you. Furthermore, you are responsible for telling us if your insurance has changed before you are seen or treated, because you may require a referral, a deductible, a waiting period on certain diagnoses and/or have a filing deadline on the new policy. You are responsible for payment if you do not inform us of new insurance prior to services. It is considered fraud not to notify your caregiver of all the insurances that you have. You may be billed for all services Dr. Lee has rendered to you this year and previous years. If you have accidentally failed to tell us about all of your insurances, now is the time to do so. To avoid any misunderstandings regarding future account balances, we require you to sign this consent prior to rendering services to you if you want us to file your insurance for you. Thank you for your cooperation.

I am aware that the insurance benefits that were obtained on my or my family member's behalf are estimates of payments and are not guaranteed by the insurance company. I agree to pay the amount due stated on the insurance company payment explanation after it is processed by them, if it was not fully collected at the time of my visit. I attest that I do not have any other insurance other than what I have given the office. I accept financial responsibility in the case of other insurance being found and prior payments recouped by the insurance company.

Patient Name (PLEASE PRINT)

Date

Patient or Guardian Signature

Moonhee Lee, M.D.

Diplomate American Board of Allergy and Immunology
Diplomate American Board of Internal Medicine

TMN: _____

DATE: _____

PATIENT INFORMATION

Patient Name: First _____ MI _____ Last _____ Sex: _____

Date of Birth: _____ / _____ / _____ Age: _____ Phone: _____

Address: _____ Apt # _____ City _____ State _____ Zip _____

Primary Doctor: _____ Occupation: _____

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Address: _____

REFERRAL SOURCE

Friend/Family Member Insurance Company Web Search Another Physician/Provider _____

EMERGENCY NOTIFICATION

1. Name: _____ Relationship to Patient: _____

Phone: _____

2. Name: _____ Relationship to Patient: _____

Phone: _____

Consent to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to use of my information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Please Initial

Accepted _____

OR

Denied _____

Signature

Date

ALLERGY AND ASTHMA CENTER OF SOUTHWEST ARLINGTON PG#2
REVIEW OF SYSTEMS

NAME: _____ **D.O.B.** _____ **TMN:** _____ **DATE:** _____

SKIN:

- Rashes
- Itching
- Swelling

HEAD:

- Headaches
- Head injury

EYES:

- Change in vision
- Redness
- Itching
- Watering
- Glaucoma/Cataracts
- Swollen eyelids

EARS:

- Change in hearing
- Ear pain, pressure
- Ear discharge
- Blocked
- Popping
- Frequent Infection
- Itching

NOSE/SINUSES:

- Nasal bleeding
- Nasal congestion
- Snoring
- Runny Nose
- Sneezing
- Loss of smell

MOUTH/ TRHOAT:

- Sore throat
- Hoarseness
- Postnasal drainage

RESPIRATORY/CARDIAC:

- Shortness of breath
- Cough
- Production of phlegm, color
- Wheezing
- Coughing up blood
- Chest pain
- High blood pressure
- Skipping heart beat
- Heart murmur
- Bronchitis/ emphysema

GASTROINTESTINAL:

- Problems Swallowing
- Nausea
- Heartburn
- Vomiting
- Constipation
- Diarrhea
- Abdominal pain
- Bloating

MUSCOLOSKELETAL:

- Pain
- Swelling
- Stiffness
- Arthritis
- Gout

NEUROLOGIC:

- Headaches
- Seizures
- Loss of consciousness/fainting
- Paralysis
- Weakness
- Numbness
- Feeling of pins and needles/tingles

ENDOCRINE:

- Abnormal growth
- Increased appetite
- Increased thirst
- Thyroid trouble
- Heat/Cold intolerance
- Excessive sweating
- Diabetes

PSYCHIATRIC:

- Tension/Anxiety
- Depression
- Suicide ideation
- Sleep Problems
- ADD, ADHD
- Autism

HEMATOLOGIC:

- Anemia
- Easy bruising
- Easy bleeding
- Past transfusions

GENERAL:

- Fatigue
- Fever
- Dizziness

Physician signature: _____

Moonhee Lee, M.D.

NAME: _____ D.O.B. _____ TMN: _____ DATE: _____

ALLERGY AND ASTHMA CENTER OF SOUTHWEST ARLINGTON

Please circle symptoms that apply.

NOSE

Runny Blocked
 Stuffy Sneezing
 Loss of smell Itchy

EYES

Watery Itchy
 Puffy lids Red
 Dark circles

EARS

Popping Blocked
 Hearing loss Itchy
 Frequent Infection

THROAT

Sore Itchy
 Drainage

CHEST

Wheeze Cough
 Phlegm Pain
 Tightness
 Shortness of breath

OTHERS

Skin rash Nausea
 Headache Fatigue
 Abdominal pain

WORST SEASON

Spring Summer
 Fall Winter
 All year

CURRENT MEDICATIONS

DRUG ALLERGIES

PETS AT YOUR HOME

Cat Horse
 Other _____ Dog

ANY ALLERGY OR ASTHMA

IN YOUR FAMILY? Y N

WHO?

Father Mother Sibling Children
 Are immunizations current? Y N