



ROBERT D. COOK, M.D., P.A.  
DIPLOMATE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

4150 NORTH LAMAR • AUSTIN, TX 78756  
PH: (512)467-0978 • FX: (512)467-8066  
centraltexasallergy.com

### **HIPPA ACKNOWLEDGMENT**

\_\_\_\_\_ I acknowledge that **Robert Cook, M.D., P.A.** has provided me with a written copy of the Notice of Privacy Practices.

\_\_\_\_\_ I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy and ask questions.

### **FINANCIAL POLICY AGREEMENT**

\_\_\_\_\_ For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

\_\_\_\_\_ I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

### **MEDICAL RECORD RELEASE**

\_\_\_\_\_ I authorize the release of any medical or other information necessary to process medical claims made to my health insurance plan. I also authorize payment of benefits by my health insurance company, to Dr. Robert Cook or to Central Texas Allergy & Asthma Center.

### **PATIENT CONTACT INFORMATION**

1. Please list the family members or other persons whom we may inform about general medical conditions or your diagnosis:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

2. Please list the family members or significant others whom we may inform about you or your child's medical condition **ONLY IN AN EMERGENCY**:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

3. Can confidential messages be left on your home telephone answering machine or work voice mail?

\_\_\_\_\_ **YES** \_\_\_\_\_ **NO**

4. Please print the telephone number where you want to receive calls about your appointments, lab and/or x-ray results, or other health care information if other than your home phone number: **Alternate phone #:** \_\_\_\_\_

### **PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient/Guardian Signature

Date: \_\_\_\_\_