



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

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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: _____