PATIENT INFORMATION

_____ HOME_____PATIENT / PARENT
TITLE FIRST NAME MI LAST NAME

CELL _____ PATIENT / PARENT

OTHER PHONE_____BELONGS TO:_____

STREET ADDRESS CITY STATE ZIP CODE

E-MAIL ADDRESS _____

DATE OF BIRTH ____/____/_____ FULL TIME STUDENT YES / NO
MALE / FEMALE
MARRIED / SINGLE

Mother / Father / Spouse / Guardian
PERSON RESPONSIBLE FOR PAYMENT (full name)

_____ CELL / HOME / WORK
GUARANTOR'S MAILING ADDRESS AND PHONE IF DIFFERENT THAN PATIENT

OTHER FAMILY MEMBERS SEEING US _____ RELATIONSHIP _____

WERE YOU REFERRED TO OUR OFFICE? NO / YES BY:_____

INSURANCE INFORMATION

PRIMARY
INSURANCE COMPANY _____
POLICY ID _____ GROUP NUMBER _____
PRIMARY SUBSCRIBER NAME: _____
PRIMARY SUBSCRIBER DATE OF BIRTH: _____
PLAN REQUIRES A REFERRAL [ ] YES [ ] NO [ ] DON'T KNOW
SPECIALIST CO-PAY $_____ [ ] NONE [ ] DON'T KNOW

SECONDARY
INSURANCE _____
POLICY ID _____ GROUP _____
SUBSCRIBER NAME: _____
SUBSCRIBER DATE OF BIRTH: _____
REQUIRES A REFERRAL _____
CO-PAY _____

EMPLOYER INFORMATION

EMPLOYER _____ PHONE _____

ADDRESS _____

OCCUPATION: _____ Full Time / Part Time / Student / Unemployed

AGREEMENTS AND AUTHORIZATIONS

I _____, hereby give my consent to Allergy and Asthma Associates to use or disclose, for the purpose of carrying out treatment, payment or health care operations, my Protected Health Information.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I _____, hereby authorize Allergy and Asthma Associate, to use or disclose Protected Health Information (PHI) by releasing my medical records to my spouse, members of my family and/or a legal or personal representative, physician(s), or entity as indicated below. I understand that the person(s) and/or entity name on this authorization will be given access to obtain or review my records and has my permission to discuss my case or obtain results information on my behalf. This authorization extends only to the person(s) and/or entity I have identified below.

_____

NAME OF FAMILY MEMBER / REPRESENTATIVE RELATIONSHIP PHONE

_____

NAME OF PHYSICIAN ADDRESS

I _____, hereby authorize payment to be made directly to Allergy and Asthma Associates, for insurance benefits payable to me. I understand that I am financially responsible to Allergy and Asthma Associates for any covered and non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer, which are not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance, may be added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorneys' fees and other costs incurred for collection.

I _____, acknowledge access to the Privacy Notice for Allergy and Asthma Associates, which provides detailed information about how the practice may use and disclose my Protected Health Information.

SIGNED _____ DATE_____

If you are not the patient, please specify your relationship to the patient.