# ALLERGY AND ASTHMA ASSOCIATES

PEDIATRIC & ADULT ALLERGY, CLINICAL IMMUNOLOGY

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*PLEASE PRINT*

## PATIENT INFORMATION

( ) -

TITLE FIRST NAME MI LAST NAME HOME PHONE

STREET ADDRESS CITY STATE ZIP

/ / MALE / FEMALE - - Married / Single / Widowed / Divorced

DATE OF BIRTH GENDER (circle one) SS# MARITAL STATUS (circle one)

YES / NO ( ) -

FULL TIME STUDENT (circle one) E-MAIL ADDRESS CELL PHONE

Mother / Father / Husband / Guardian

PERSON RESPONSIBLE FOR PAYMENT (full name) RELATIONSHIP (circle one)

STREET ADDRESS CITY STATE ZIP
(give full address of person responsible for payment if other than patient)

YES / NO

OTHER FAMILY MEMBERS SEEING US? (circle one) IF YES, GIVE NAME RELATIONSHIP

YES / NO

HAVE YOU BEEN REFERRED TO OUR OFFICE? (circle one) IF YES, GIVE NAME

## INSURANCE INFORMATION

INDEMNITY / PPO / HMO / POS ( ) -

INSURANCE NAME INSURANCE TYPE INSURANCE PHONE

STREET ADDRESS CITY STATE ZIP

POLICY ID# GROUP NAME GROUP # EFFECTIVE DATE

$ $ $

DEDUCTIBLE AMOUNT INSURED NAME (if other than patient) YOUR % SHARE AFTER DEDUCTIBLE YOUR COPAY



**TURN OVER**

## EMPLOYER INFORMATION

( ) -

EMPLOYER'S NAME EMPLOYER'S PHONE

STREET ADDRESS CITY STATE ZIP

Full Time / Part Time / Student / Unemployed

EMPLOYMENT STATUS (circle one) OCCUPATION

## 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 Associates, 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.

( ) -

GIVE NAME OF FAMILY MEMBER RELATIONSHIP PHONE

GIVE NAME OF PHYSICIAN ADDRESS CITY STATE ZIP

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. 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 receipt Notice of Privacy Practices from 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.