

INFORMATION SHEET FOR ALLERGY ASTHMA SPECIALISTS, P.A. (AAS)

Patient's Name: _____ DOB: ____/____/____ SS# _____
(Legal name) First MI Last Mo Day Year

Marital Status: M S D W Sex: M - F Race: W -B- H- A Smoker? Yes or No

Patient Address: _____
Street/ APT # City State Zip

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone (____) _____

EMAIL ADDRESS _____ College Student FULL PART -TIME

PRIMARY CARE = REFERRING DOCTOR and EMERGENCY INFORMATION

Primary Physician's Name: _____ Phone (____) _____

Address: _____

Referring Physician If Different: _____ Phone (____) _____

EMERGENCY Contact Name: _____ Home/Cell (____) _____

Address: _____ Work Phone (____) _____

PATIENT COMPLETE: *** MUST COMPLETE *******

Patient's Employer: _____ Work Phone (____) _____

Employer's Address: _____

Spouse's Name: _____ Cell Phone: (____) _____

Spouse's Employer: _____ Work Phone (____) _____

IF PATIENT IS A Child or College Student *** MUST COMPLETE *******

Mother: _____ DOB: _____ SS # _____

Mother's Employer: _____ Work Phone (____) _____ ex _____

Father: _____ DOB: _____ SS#: _____

Father's Employer: _____ Work Phone (____) _____ ex _____

Address: _____

If different from child Street / APT# City State Zip

Home Phone: (____) _____ Cell Phone: (____) _____

INSURANCE INFORMATION: *** MUST COMPLETE *******

Insurance Company: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ Policy Holder SS#: _____

Insurance CLAIMS Address: _____

Policy Holder's Employer: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Insurance CLAIMS Address: _____

Policy Holder's Name: _____ DOB: _____ Policy Holder SS#: _____

DATE AND INITIAL year 1 ____/____/____ year 2 ____/____/____ year 3 ____/____/____

INFORMATION ON APPOINTMENT SCHEDULING

URGENT APPOINTMENTS are USUALLY brought in and seen the same day you call in. **If you need emergency care call 911 or go to the nearest Emergency Facility.** If you frequent our office for your allergy injections **and have questions for a nurse / doctor or if you are ill PLEASE CALL AND MAKE AN APPOINTMENT.** This allows us to book the appropriate amount of time needed with the Doctor this will reduce your wait time. **If you are more then 20 minutes late without notification to your appointment it may have to be rescheduled to another day, if possible we will work you in.**

FINANCIAL ARRANGEMENTS:

Payment must be paid at the time your appointment. This includes all Co-payments and deductibles. We accept **Cash, Personal Checks, Master Cards, Visa and Discover.** There is a **\$30 CHECK RETURN FEE** for each check that is returned. If we get a NSF check only cash or credit card will be accepted. **If other financial arrangements need to be made, you must speak to our Business Office before your schedule appointment. AAS does utilize a collection agency for over due accounts.**

CANCELLATION FEE:

All appointments that are not kept will be charged \$30, for Failure to cancel my appointment 24 hours prior to the scheduled appointment time. This fee will be charged to your account, Payable on or before your next appointment. **TO ALL PATIENT: FAILURE TO KEEP OR CANCEL UP TO THREE APPOINTMENTS CAN RESULT IN THE DISCHARGE FROM ALLERGY ASTHMA SPECIALIST,** THE DECISION TO DISCHARGE A PATIENT FROM OUR CARE WILL BE AT OUR DISCRETION. **PLEASE DO NOT LET THIS HAPPEN TO YOU.** **New patient appointments are subject to a \$50 charge for appointments not canceled 24hrs in advance.**

HMO /PPO /POS/MEDICARE HMO/TRICARE HMO PATIENTS:

YOU Must obtain a prior authorization number/referral from your primary care physician before each visit or injection to our office. I understand if a referral/number is not issued MY APPOINTMENT WILL BE RESCHEDULED I understand I am responsible for any balance of unauthorized visits or procedures. **(Please Initial) _____**

ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to Allergy Asthma Specialists, P.A. (AAS) of medical benefits or Medicare benefits otherwise payable to me under the terms of my policy for the claims filed by AAS, but not to exceed my indebtedness to AAS. In making this assignment to AAS, I understand and agree that any unpaid balances not covered by this policy/Medicare plan, **will be payable by me.** I authorize Medicare to make payment for services rendered directly to Allergy Asthma Specialists, P.A. **I understand I must provide current insurance information at each visit and a Photo ID.** I agree to be financially responsible for payment of all services on my behalf or my dependents. **I hereby certify the information provided is correct and true to the best of my knowledge.**

X _____ Date: _____
Signature of Patient/Guardian Print Name

AUTHORIZATION AND RELEASE:

I **Authorize** ALLERGY ASTHMA SPECIALIST, P.A. to **release or obtain** any/all information needed to file a medical claim and or treat, diagnose, including my medical records and diagnosis of any treatment or examination rendered to me or my dependent during the period of such care, including, Office notes, Allergy test, Pulmonary Test, Labs, Radiology, my insurance company information, including third party payers and/or other health practitioner or medical facility including Medicare/Social Security Administration & Health Care Financing Administration or its intermediaries. I **Authorize** my insurance company/Medicare/Social Security Administration & Health Care Financing Administration or its intermediaries to review any/ or all parts of my medical records, for the sole purpose of quality assessment and payment. I **Authorize** ALLERGY ASTHMA SPECIALIST, P.A. and the health care staff to perform the necessary medical services I or my dependent may need. **This consent is good for the entire time period I or my child(ren) am/are a patient .**

X _____ Date: _____
Signature of Patient/Guardian Print Name