



**INFORMATION ON APPOINTMENT SCHEDULING**

Our office usually schedules follow appointments when you check out. This allows you a better choice of times that will best fit your schedule, if not reminder follow cards will be sent to your home. **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 come on a routine basis for your allergy injection **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 and to ensure the chart is ready. **If you are more than 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 is expected at the time your appointment.** This includes all **Co-payments.** We accept **Cash, Personal Checks, Master Cards, Visa and Discover.** There is a **30 Dollar CHECK RETURN FEE** on each check that is returned. **If other financial arrangements need to be made, they must be made when you schedule your appointment.**

**CANCELLATION FEE:**

**Failure to cancel your appointment 24 hours prior to the schedule appointment will result in a \$25 Dollar fee 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.**

**HMO /PPO /POS/ PATIENTS:**

**Please obtain prior authorization/referral from your primary care physician before each visit or injection to our office. I understand if a referral is not issued, I will be responsible for any unpaid/not covered balance.** *(Please Initial)*

**ASSIGNMENT OF BENEFITS:**

I hereby authorize payment directly to Allergy Asthma Specialists, P.A. of benefits and/or major medical benefits otherwise payable to me under the terms of my policy but not to exceed my indebtedness to said physician for his/her services. In making this assignment to the physician, I understand and agree that any unpaid balances not covered by this policy will be payable by me. I understand I must provide current insurance information at each visit. 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 treat and or 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, Allergy test, Pulmonary test, Labs, Radiology, my insurance company information, including third party payers and/or other health practitioner or medical facility.

I **Authorize** my insurance company to review any/ or all parts of my medical records, for the sole purpose of quality assessment.

I **Authorize** ALLERGY ASTHMA SPECIALIST, PA and the health care staff to perform the necessary medical services I or my dependent may need. **This consent expires one year from the date signed, therefore must be signed yearly.**

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Signature of Patient/Guardian** **Print Name**