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 Domestic Partner **Sex:** M – F **Race:** W -B- H- A- Mix **Smoker?** Yes or No
Ethnicity CIRCLE ONE: Caucasian African-American Hispanic Latino American Indian Non Hispanic Asian Island Pacific Hawaiian Multi
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: _____
Pharmacy Name: _____ City_____ **Phone** (_____)_____

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

Address: _____**Work Phone** (_____) _____

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

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

Employer's Address: _____

Spouse/Partner's Name: _____**Cell Phone**: (_____) _____
Spouse/Partner'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** _____/_____

FINANCIAL RESPONSIBILITES

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.**

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/ MEDICAID/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.
(*Initial*)_____

AUTHORIZATION AND RELEASE:

I **Authorize** ALLERGY ASTHMA SPECIALISTS, 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 SPECIALISTS, 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

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

FINANCIAL RESPONSIBLILIES

Payment must be paid at the time your appointment. This includes all **Co-payments and deductibles**. We accept **Cash**, **Personal Checks, American Express, 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 in future. **If other financial arrangements need to be made, you must speak to our Business Office before your schedule appointment. I here by agree to AAS policy. AAS does utilize a collection agency for over due accounts.**

X_____ Date: _____
Signature of Patient/Guardian Print Name