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
Gender Patient Identify with M F other **Sexual Orientation** Straight Bisexual Lesbian Gay Other Decline to answer
Patient Address: _____
Street APT # City State Zip
***Cell Phone*: (_____)_____ Home Phone:** (_____)_____
***EMAIL ADDRESS*:** _____

PRIMARY CARE REFERRING DOCTOR PHARMACY

Primary Physician's Name: _____ **Phone** (_____)_____
Address: _____city_____**Fax**(_____)_____

Ref Doctor : _____**Phone: (**_____**)**_____ **Fax: (**_____**)**_____

Pharmacy Name: _____ City_____ **Phone** (_____)_____
PHARMACY PLAN or (MEDICARE PART D)_____
Give your card to the Front Desk to Scan

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

Insurance Company: _____
Policy #:_____ **Group #**: _____
CLAIMS Address: _____
Insurance Phone: (_____**)**_____
Policy Holder's Name: _____**DOB**:_____/_____/_____
Policy Holder SS#:_____/_____/_____ **relationship self spouse child other**
Home Address if different:
_____**city**_____**st**_____**zip**_____

Secondary Insurance: _____
Policy #: _____ **Group #**:_____
CLAIMS Address: _____
Insurance Phone: (_____**)**_____
Policy Holder's Name: _____**DOB**:_____/_____/_____
Policy Holder SS#: _____/_____/_____ **self spouse child other**
Home Address if different:
_____**city**_____**st**_____**zip**_____

PATIENT EMPLOYER **** MUST COMPLETE ****** SPOUSE OR PARTNER**

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

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

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

Mother: _____**DOB:** _____/____/_____ **SS #**_____
Mother's Employer: _____ **Cell Phone** (_____)_____

Father: _____**DOB:**_____/_____/_____**SS#:**_____
Father's Employer: _____ **Cell Phone** (_____)_____

Address: _____
If different from child Street / APT# City State Zip

DATE AND INITIAL _____/_____

APPOINTMENT 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. ***Appointments usually take 2 hours per visit***. **If you are more then 20 minutes late without notification to your appointment time it may have to be rescheduled to another day, if possible we will work you in.**

CANCELLATION / No Show FEE:

All appointments that are not kept or canceled 24 hr in advance of your appointment will be charged $50, To cancel an appointment I must call the office during business hours, If I call the after hours doctor to cancel or change an APPT I will be charged $50 for that call, 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.**

REFERRALS Commercial HMO /PPO /POS/ MEDICARE MANAGED CARE MEDICAID PLANS TRICARE

I must obtain a prior authorization number/referral from My primary care physician before each visit or injection to our office if my Insurance Plan requires this. I understand if a referral/number is **not** issued **MY APPOINTMENT WILL BE RESCHEDULED** I understand I am responsible for any Services provided that I did not get the proper authorization for prior to treatment by AAS.

(*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, prescribe medication, 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) is/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

If I have an HMO Plan that requires a Referral I understand I will have to pay for all treatment provided by AAS should My PCP fail to send MY Referral prior to services being rendered. I have notified my PCP of Appt date. 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**, **Secure Payments can be made Online via our Website, AllergyCFL.com** There is a **$50 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