Asthma & Allergy Physicians

PATIENT REGISTRATION FORM

Date_____

Patient Name _____ _____ _____
Last First M Initial

Street Address 1 _____ **Street Address 2**_____

City/Town_____ **State**_____ **Zip Code**_____

Sex (M/F) ___**Date of Birth** _____ **Marital Status** ___

Phone Numbers:
Home ( ) _____
Cell ( ) _____
Work ( ) _____
EXT_____
Please update any changes

Race: *(circle one)*
American Indian or Alaskan Native
Asian
Black or African American
White Caucasian
Native Hawaiian or other Pacific Islander
Other Race

Language: *(circle one)*
English
Chinese
Cape Verdean Creole
Japanese
Haitian Creole
Russian
Portuguese
Spanish
Sign Language
Other

Ethnicity: *(circle one)*
Hispanic or Latino
Not Hispanic or Latino
Refused to report

Email address _____@_____ (parent if patient is under 18)
Circle one ~~~Patient Mother Father (Name_____)

Parent/Guardian Name _____Full time student? **Y or N**
Employed? **Y or N** ***Name of Employer***_____

Emergency Contact _____**Phone (** **)**_____**Relationship**_____
(relative, friend, etc)

Address _____

(statements will be addressed to financially responsible party)
Responsible Party:_____ DOB:_____ Address_____
If other than patient Street City/Town State Zip

Relationship of patient to Resp. Party. Self Spouse Child Grandchild Parent *(Circle)*

Name of Primary Care Physician _____
First Name Last Name

Address _____ _____**Phone (** **)** _____
Street City/Town State ZIP

Physician Specialist **(that you may want a report sent to)**_____
First Name Last Name Address

Preferred *Local* Pharmacy _____ _____
Name Address

_____ _____ _____ _____
City/Town State Zip Telephone No

Preferred *Mail Away* Pharmacy _____ _____
Name Address

_____ _____ _____ _____ _____
City/Town State Zip Telephone No Certificate Number (Express Scripts or Medco, etc.)

Insurance

Name of Insurance Company _____Subscriber's Name _____
Subscriber's DOB _____Identification Number _____Group Number _____
Effective Date of Coverage _____ Relationship to patient _____ Co- pay amount _____
Subscriber's Employer _____Does your insurance require a referral? Y or N

Secondary Insurance

Name of Insurance Company_____ Subscriber's Name _____
Subscriber's DOB _____Identification Number _____Group Number _____
Effective Date of Coverage _____ Relationship to patient _____Subscriber's Employer _____

Privacy Notice Acknowledgement Form

I have had the opportunity to review Asthma and Allergy Physicians' Notice of Privacy Practices. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, the payment of my bills, and health care operations of the practice including possible future participation in clinical research trials. My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider or health plan. This protected health information relates to all my medical conditions and identifies me. The Notice of Privacy Practices for Asthma and Allergy Physicians is available upon my request. Asthma and Allergy Physicians reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice including possible future participation in clinical research trials. Asthma and Allergy Physicians is not required to agree to the restrictions that I may request. However, if Asthma and Allergy Physicians agrees to a restriction that I request, the restriction is binding on Asthma and Allergy Physicians.

Signature _____ Date _____

I give Asthma and Allergy Physicians permission to share my health information with:

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

FINANCIAL POLICY

Thank you for allowing us to serve your allergy/asthma needs. As an accommodation to our patients, we have adopted the following payment policy, which will allow us to continue to provide the best care available. Payment is due at the time services are rendered.

TYPE OF PAYMENT: We accept cash, check, Visa, MasterCard or American Express.

INSURANCE: Patients are responsible for payment of all services. Asthma and Allergy Physicians will submit your claims to your insurance company if proper referrals are in place. Some insurance companies apply skin testing, patch testing and pulmonary function tests to a deductible or co-insurance. This will be your financial responsibility.

REFERRALS: Patients who require referrals from their PCP must have them in place for any future visits: If Asthma and Allergy Physicians does not have a current referral in place, the scheduled appointment may have to be rescheduled.

DEDUCTIBLE & CO-INSURANCE: Some insurance companies apply skin testing, patch testing and pulmonary function tests to a deductible or co-insurance. This will be your financial responsibility. I have read, understand and agree with the above Financial Policy. I hereby authorize Asthma and Allergy Physicians to directly bill my insurance for services rendered to me and authorize direct payment to Asthma and Allergy Physicians for these services. I understand that I may be financially responsible for charges not covered by my insurance.

Signature _____ Date _____

MEDICATION POLICY: Requests for medication refills will only be filled Monday through Friday from 9 a.m. to 4:45 p.m. Please be certain to check your medicine supplies periodically to ensure adequate supplies through weekends/holidays.

Signature _____ Date _____

CANCELLATION POLICY: Twenty-four (24) hour notice is required in order to avoid a $40 missed office visit appointment fee or injection appointment fee.

Signature _____ Date _____

CONFIRMATION POLICY

By checking this ☐ box and signing your name below, you agree that we may call you at the number you entered above with reminders, offers and other info, including possibly using automated technology, text and recorded messages. Consent is not a condition of purchase. [Standard rates apply.] Cell Phone Number _____

By giving us your phone number, you consent to receive messages using automated technology, text and recorded messages?

Signature _____ Date _____