ALBEMARLE ASTHMA & ALLERGY ASSOCIATES, PA

PATIENT INFORMATION SHEET

DATE ____________ PATIENT NAME ____
FIRST M LAST

MAILING ADDRESS ____
BOX/STREET CITY STATE ZIP

PHONE (HM) ____________ (CELL) ____________ (WK) ____________

DATE OF BIRTH ____________ AGE ____________ SSN ____________

RACE ____________ ❑ FEMALE ❑ MALE MARITAL STATUS S / M / W / D

EMPLOYER ____________ OCCUPATION ____________

EMAIL ADDRESS ____________ (WITH AN EMAIL, YOU CAN USE OUR PATIENT PORTAL)

EMERGENCY NOTIFICATION

NAME ____________ PHONE ____________ RELATIONSHIP ____________

LIST ALL MEDICATIONS ____

____

DRUG ALLERGIES ____

WHICH PHARMACY DO YOU USE? ____________ FAMILY DOCTOR ____________

PARENT/GUARDIAN INFORMATION

MOTHER ____________	FATHER ____________
DOB ________ SSN ________	DOB ________ SSN ________
ADDRESS ____________	ADDRESS ____________
HOME PHONE ____________	HOME PHONE ____________
CELL PHONE ____________	CELL PHONE ____________
WORK PHONE ____________	WORK PHONE ____________

PRIMARY INSURANCE ____________ POLICY NUMBER ____________

POLICY HOLDER'S NAME ____________ SSN ____________

DATE OF BIRTH ____________ RELATIONSHIP TO PATIENT ____________

SECONDARY INSURANCE ____________ POLICY NUMBER ____________

POLICY HOLDER'S NAME ____________ SSN ____________

DATE OF BIRTH ____________ RELATIONSHIP TO PATIENT ____________

ASSIGNMENT OF BENEFITS

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST THAT PAYMENT OF BENEFITS BE MADE TO ALBEMARLE ASTHMA & ALLERGY WITH THE UNDERSTANDING THAT ANY UNPAID BALANCE FROM COPAYS, DEDUCTIBLES, NON-COVERED CHARGES OR FEES ASSOCIATED WITH COLLECTION AGENCY PLACEMENT WILL BE MY RESPONSIBILITY. THERE IS A $25 NO-SHOW FEE FOR FAILURE TO GIVE 24 HOURS NOTICE FOR CANCELLATIONS.

____ ____________________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

Albemarle Asthma & Allergy Associates, PA

Medical History Sheet

Name ______________________ DOB ______________________

Referred by ______________________ Date ______________________

REASON FOR VISIT TODAY:

MEDICAL HISTORY

Do you or any family member have a history of any of the following:

	Patient	FAMILY HISTORY Mother	Father	Brother	Sister	Daughter	Son
Allergies	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Heart Trouble	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐
Skin Problems	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
None of the above:	☐	☐	☐	☐	☐	☐	☐

DRUG ALLERGIES / TYPE OF REACTION

____

____

FOOD ALLERGIES / TYPE OF REACTION

____

SURGERY OR OVERNIGHT HOSPITALIZATIONS

____

____

SOCIAL HISTORY

Are you a smoker? ________

If yes,
Interested in quitting _____ Ready to quit _____ Thinking about quitting _____ Not ready to quit _____
How long have you smoked ______________ How many cigarettes do you smoke per day __________

Are you a former smoker?
How long did you smoke __________ How many per day _________ What year did you quit ________

Do you drink alcohol? ___ yes ___ no How much? _________ If no, did you previously? ___ yes ___ no

Do you have any pets? ___ yes ___ no #Cats ______ #Dogs ______ Other ____________

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ALBEMARLE ASTHMA & ALLERGY ASSOCIATES, PA

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by ALBEMARLE ASTHMA & ALLERGY or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

ALBEMARLE ASTHMA & ALLERGY may or may not agree to restrict the use or disclosure of your protected health information.

If ALBEMARLE ASTHMA & ALLERGY agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
ALBEMARLE ASTHMA & ALLERGY reserves the right to modify the privacy practices outlined in this notice.

Signature
I have reviewed this consent from and give my permission to ALBEMARLE ASTHMA & ALLERGY to use and disclose my health information in accordance with it.

_________________________________ **NAME OF PATIENT**

_________________________________ **SIGNATURE OF PATIENT/DATE**

DESIGNATED INDIVIDUALS AUTHORIZATION

Do we have permissions to?

Leave a message on your home answering machine/voicemail? Yes No

Leave a message at your employment? Yes No

Discuss your medical condition(s) with a family member/member of your household/friend/other? Yes No

If yes, whom: _________________________ Relation: _________________

Release any of your medical information (office notes, path reports, lab results to a family member/member of your household/friend/other?)

If yes, whom: _________________________ Relation: _________________

Patient or Guardian: _________________________________
(Print)

Patient or Guardian: _________________________________
(Signature) Date

ALBEMARLE ENT ASTHMA & ALLERGY ASSOCIATES, PA

FINANCIAL POLICY

YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BALANCE REGARDLESS OF INSURANCE COVERAGE OR LIABILITY OF ANOTHER PARTY.

Insurance – We will file personal health insurance for you with the information you furnish at the time of the appointment. It is patient responsibility to inform us anytime there is a change in your insurance coverage.

Deductibles & copays – We expect payment at the time of service for all copays and deductibles. We accept cash, check, Mastercard, Visa, Discover and American Express. If copay is not paid at the time of service, we will add $5 to offset the cost of billing.

Self pay patients – For our patients without insurance, we offer a 20% discount **if payment is made at the time of the visit.**

Refunds – We send out refund checks monthly for amounts over $20. Credit balances less than $20 will stay on the account to be used towards future visits. If patients choose to prepay, credit balances will be used to offset any future patient balances.

Billing – Unpaid balances, copays and deductibles will be billed a total of 3 times after insurance pays. After the 3rd statement a collection letter will be generated. After 15 days, if the balance is not paid the account may be turned over to an outside collection agency. Collection fees of **$50.00** will be assessed to the account due to the fact that it is very labor intensive to prepare the accounts for transferring to an outside agency.

Allergy Patient Balances – Patient account balances that are delinquent or have become excessive, must be reviewed by a patient account specialist before retesting or remixing serum can be done. The amount the patient is required to pay will be determined and a payment arrangement will have to be agreed upon and signed in order to proceed.

Medicaid patients must bring their Medicaid/NC Health card and copay if applicable. Failure to do so may result in rescheduling your appointment for another date. In the event that a patient fails to show up for appointment or cancels without 24 hr notice twice, we may consider terminating that patient.

Missed Appointments -Patients may be accessed a $25 fee for no shows or failure to give at least 24 hour notice.

I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THE ABOVE POLICY REGARDING PAYMENT OF MY ACCOUNT AT ALBEMARLE ENT ASTHMA & ALLERGY ASSOCIATES.

____ ____________________

Patient/Guarantor Signature Date