ALLERGY & ASTHMA SPECIALISTS, P.C.

(Please fill out completely)

Appt. Date_____

PATIENT REGISTRATION

Patient Name _____Date of Birth _____Age:_____

Address_____City_____State_____Zip_____

Phone (_____)_____ Cell (____)_____ Sex M F Social Security #_____

Occupation_____Marital Status: _____

Patient's Employer_____Phone(_____)_____Ext._____

Address_____City_____State_____Zip_____

Responsible party (mother, father, guardian, self etc.)_____DOB_____

Address (if different from patient)_____City_____State_____Zip_____

Phone (_____)_____ Social Security #_____

PRIMARY INSURANCE Relationship to patient_____

Subscriber Name_____M F DOB_____Social Security #_____

Address (if different from patient)_____City_____State_____Zip_____

Subscriber's Employer_____Phone(_____)_____Ext._____

Employer's Address_____City_____State_____Zip_____

Ins. Co._____I.D.#_____Grp Name or number_____

SECONDARY INSURANCE Relationship to patient_____

Subscriber Name_____M F DOB:_____Social Security #_____

Address (if different from patient)_____City_____State_____Zip_____

Subscriber's Employer_____Phone(_____)_____Ext._____

Employer's Address_____City_____State_____Zip_____

Ins. Co._____I.D.#_____Grp Name or number_____

LOCAL PHARMACY _____Addr _____ City _____ State_____

MAIL-AWAY PHARMACY_____Addr_____City_____State_____

Phone (_____)_____ Fax (_____)_____

EMERGENCY CONTACT (***Preferably someone who does not live with you***)

Name _____Phone(_____)_____Relationship _____

YOUR PHYSICIAN (Your primary care physician or the physician who referred you to AAS)

M.D. Name_____Phone(_____)_____

Address_____City_____State_____Zip_____

(over) please read and sign the back of this form

ALLERGY & ASTHMA SPECIALISTS, P.C.

Our priority is providing you with quality healthcare. We ask that all new patients or their guarantors present a valid insurance card and driver's license/photo identification upon check-in at each appointment.

- **Patients with insurance which we are participating/contracted with** are expected to have copayments at the time of services. You should contact your insurance company to be sure of your coverage for allergy services.
- **What if I do not have insurance or you are not a participating provider for my carrier?**
  For patients who do not carry health insurance and those for whom we do not accept their policy, payment will be expected in full at the time of the visit. Anyone who feels it is necessary to extend payments over a period of time is invited to discuss arrangements with our billing department prior to their visit.
- **What if my insurance plan requires a referral and/or prior authorization?**
  For patients' whose insurance company requires a referral and/or a prior authorization, please contact your primary care physician prior to your appointment in our offices. If your insurance company requires a referral and/or prior authorization and you do not have one – you may NOT be seen for your scheduled appointment, or you will responsible for full payment of your bill at the time of service.
- **What are my financial responsibilities as a patient?**
  As a patient, it is in your best interest to know and understand your responsibilities for **any deductibles, co-insurances, or copayment amounts** prior to any visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill. If you do not notify our office of a change in coverage at the time of your appointment and your claim is denied as a result, you will be responsible for the charges of the claim in full.
  To find out what your insurance plan covers and what your financial obligation may be, call the Customer Service or Member Services Department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Financial Policy My signature below acknowledges that I have read and understand the conditions for payment to Allergy & Asthma Specialists, P.C. as outlined above.

Signature:_____ Date:_____

Consent to Bill My signature below acknowledges that I give permission for Allergy & Asthma Specialists, PC to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services. Such necessary information may include my diagnosis, services dates, types of service and other information related to services necessary to process claims.

Signature:_____ Date:_____

Privacy Policy My signature below acknowledges my right to receive HIPAA policy information and I may request a copy at the time of my appointment.

Signature:_____ Date:_____

We accept cash, personal checks, Visa, MasterCard, Discover and American Express.