PATIENT REGISTRATION AND CONSENT FORM

PATIENT

First name: __________________________ Last name: ______________________________M.I.: _______

Address: ____

City/State/Zip: ____

Home Phone :(____) ____-_________ Work Phone: (____) ____-__________ Cell: (____) ____-______

May AAIC leave messages on your Home Phone? ____ (y/n) Work Phone? ____ (y/n) Cell? ____ (y/n)

Birth Date: _________________________ Social Security Number: ________________________________

Sex: □Male □Female Marital Status: □Married □Single □Divorced □Separated □Widowed

Employment Status: □Full Time □Part Time □Retired Student Status: □Full Time □Part Time

Primary Care Physician (Name and Clinic): ____

Referring Physician – if not Primary Physician (Name and Clinic): _________________________________

RESPONSIBLE PARTY ***(If someone other than patient.)***

First name: __________________________ Last name: ______________________________M.I.: _______

Address: ____

City/State/ Zip: ____

Home Phone :(____) ____-_________ Work Phone: (____) ____-__________ Cell: (____) ____-______

Birth Date: ____________________ Soc. Security Number: ______________________________________

□Responsible Party is also the Policy Holder for Patient □Primary Insurance □Secondary Insurance

INSURANCE INFORMATION

Name of Insured: ________________________ Relationship to Patient: □Self □Spouse □Child □Other

Plan/Policy #: ______________________________ Group #: ____________________________________

Employer: ______________________________ Insurance Company: _______________________________

Address: ____________________________ City/State/Zip: ______________________________________

Secondary Insurance ***(if any):***

Name of Insured:_______________________ Relationship to patient: □Self □Spouse □Child □Other

Plan/Policy #: ______________________________ Group #: ____________________________________

Employer: ______________________________ Insurance Company: _______________________________

Address: ____________________________ City/State/Zip :______________________________________

I authorize release of any medical information necessary to process my claim for services provided by AAIC.

____
(Patient/Guardian Initials)

I authorize payment directly to AAIC.

____
(Patient/Guardian Initials)

I authorize release of my health records to any provider who is being advised or consulted with in connection to my current treatment.

____
(Patient/Guardian Initials)

How did you hear about AAIC? (Circle One)

Newspaper (which one) _________________
Internet
Employer
Physician Referral
Yellow Pages
Brochure
Hospital
Friend/Relative
Other______________

I understand that I am responsible for the charges for all services rendered toward myself or the Patient, by Allergy, Asthma, & Immunology Clinic, P.A. (referred to throughout this document as “AAIC”). As the Patient/Responsible Party, I understand that I am personally responsible to ensure payment on any account balance within thirty (30) days of services rendered. If for any reason insurance does not pay for a portion of the account balance, I will make prompt arrangements to pay the account myself. I understand that an AAIC account becomes past-due after 120 days. I further understand that if I neglect to make payments on a past-due account, AAIC will use an attorney for collection and that I shall be personally responsible for all reasonable costs of collection. I also understand that AAIC shall charge an interest rate of five percent (5%) on all past-due accounts.

I understand that it is my responsibility to obtain pre-authorization for treatment, if required by insurance, and that I am responsible for any charges insurance does not pay because pre-authorization was not obtained. I further understand that co-payments or other payments that insurance plans do not cover for services rendered by AAIC are due at the time of service. In the event my insurance carries a deductible over $1,000.00, I understand that AAIC reserves the right to collect fifty-percent (50%) of the payment up-front, prior to service.

Payments to AAIC may be made in cash, by personal check, or on a MasterCard or Visa. I understand that personal checks returned without sufficient funds will result in a $25.00 NSF fee.

It is AAIC’s policy to strive to comply with all state and federal laws regarding patient privacy. I acknowledge that I have been offered a copy of AAIC’s Notice of Privacy Practices as posted in the reception area. I also understand that I have a right to receive a copy of these privacy practices at any time upon request.

Patient/Guardian’s Signature: ___________________________ Relationship to Patient: ______________________ Date:____________________

THIS SIGNATURE DOES NOT EXPIRE. YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.