Allergy, Asthma, & Clinical Immunology Specialist, P.C.

Rebecca B. Raby, M.D. Heather C. James, M.D.

PATIENT INFORMATION FORM

Patient Name: ______________________________

Address: ______________________________

City: ____________________ St.: __________ Zip: __________

Best Contact Phone #: ( ) ____________ Alt Ph #: ( ) ____________

E-mail: ____________________

Date of Birth: __________ SS#: __________ Sex: M or F Race: __________

Ethnicity: ____________________ Language: ____________________

Marital Status: S M W D Spouse's Name: ____________________

Person Responsible for Account: ____________________ Relationship: __________

Address: ____________________ City: __________ St.: ______ Zip: ______

Employer: ____________________ Position: ____________________

Work Ph #: ( ) ____________ Parent/Spouse: Employer: ____________________

Position: ____________________ Wk. #: ( ) ____________

Notify in Case of Emergency: ____________________ Relationship: __________

Ph #: ( ) ____________

Referred By: ____________________ **Primary Doctor:** ____________________

********* Preferred Pharmacy:**____________________

Please select: Do you prefer: 30 day or 90 day prescriptions

Primary Ins. Info.

Ins. Co.: ____________________ Insured Name: ____________________

Relation to Patient: __________ DOB: __________ SS#: __________

Policy #: __________ Group #: __________ Co-Pay Amt.: $______

Address if different from patient: ____________________

Secondary Ins. Info.

Ins. Co.: ____________________ Insured Name: ____________________

Relation to Patient: __________ DOB: __________ SS#: __________

Policy #: __________ Group #: __________ Co-Pay Amt.: $______

Address if different from patient: ____________________

******Prescription Drug Card Info.**

Ins. Co.: ____________________ Policy #: ____________________

RxBID #: __________ RxPCN #: __________ RxGrp #: __________

Please Read & Sign

I hereby authorize payment of medical benefits directly to physician of benefits due me or my dependents for the services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

____________________ ____________

Signature Date

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES FORM which details how Protected Health Information may be used and disclosed.

____________________ ____________

Signature Date

For Internal Use Only

An attempt was made to obtain acknowledgement of the NOTICE OF PRIVACY PRACTICES on:

The acknowledgement was not obtained because: The patient declined to sign or Other:

Name of Patient: ____________________ Staff Member: ____________________ Date: __________

Allergy, Asthma, & Clinical Immunology Specialists, P.C.

Heather C. James, M.D.   Rebecca B. Raby, M.D.

Our physicians are certified by the American Board of Allergy and Immunology.

CONSENT TO RELEASE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, or HEALTHCARE OPERATIONS:

I hereby authorize A.A.C.I.S., P.C., to provide me with reasonable and proper medical care in accordance with the standard of care at the time care is provided, including but not limited to office visits, allergy testing, PFT testing, allergy injections, immunizations and/or nebulized bronchodilator treatments.

I hereby authorize payment by an insurer directly to A.A.C.I.S., P.C., for all benefits payable under the terms of the insurance policy during the period of services rendered. A.A.C.I.S., P.C., accepts assignment of insurance benefits from some insurance companies. If arbitrary determination of a participating insurance company indicated that charges are cosmetic or not medically necessary, the patient/ guarantor will be responsible for the outstanding balance.

For insurance companies, with which A.A.C.I.S., P.C., does not participate, payment is due in full at the time of service. Please check with the registration clerk to confirm if your insurance is considered participation or non-participating. However, it is ultimately the responsibility of the patient/ guarantor upon request, the claim form required to file with non-participating insurances indicating that payment is due to the guarantor/ patient. I understand that the insurance contract may not cover all charges for medical services. Three statements will be generated in the course of an outstanding balance. After which a final notice prior to collections will be mailed. Payment in full is expected on outstanding balances. If a payment plan is absolutely necessary, the terms and conditions will be deemed acceptable by A.A.C.I.S., P.C., not upon the financial plan determined by the client. I further understand that there will be a 55% charge plus postage added to the outstanding balance due if debt is referred to a collection agency for collection. If medical treatment. Any person signing this agreement as “Guarantor” unconditionally agrees to fully pay charges (and, if appropriate, collections agency fees) owing by the above-mentioned patient and remaining unpaid balance over thirty days after the rendering of services by A.A.C.I.S., P.C..

COPAYS and NON-PARTICIPATING

COPAYS are due at the time of service. Those patients with **NON- PARTICIPATING** insurance companies are responsible to pay the balance accrued each service after the services are rendered. We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefit. In order to achieve this, we need your assistance and understanding of our payment policy. Our office participates with a variety of insurance plans; however, **WE ARE NOT MEDICAID PROVIDERS**.

*It is your responsibility to **bring your insurance cards and your prescription drug cards** with you to every visit and be prepared to pay your copay at each visit.*

VACCINE POLICY:

A.A.C.I.S., P.C., follows the guidelines of the Advisory Committee on Immunization Practice (ACIP) of the Center for Disease Control (CDC) and the American Academy of Pediatrics regarding immunizations.

OUR PHYSICIANS DO NOT ACCEPT PATIENT FAMILIES UNWILLING TO ADHERE TO THESE IMMUNIZATION SCHEDULES.

APPOINTMENTS

Patients are seen on a scheduled appointment basis. Please make an appointment for all office visits. Unless an appointment is cancelled 24 hours in advance, A.A.C.I.S., P.C., will charge a **$25 missed appointment fee.** This fee is not a billable charge to insurance company and is the patient's responsibility.

I have read and understand the above policies.

_______________________________   _______________________________

Patient/Guarantor   Date