Patient's Last Name _____ First Name_____ Middle Initial ____

SSN _____ Date of Birth _____ Age _____ Sex: F M

Address _____ Apt.#_____ City _____ State _____ Zip _____ County_____

Pharmacy Name and address_____

Name & Address of Primary Care (Family) Physician / Pediatrician _____

Referring Physician Name & Address (if different) _____

Marital Status: Single Married Divorced Widowed Separated Student Status: PT FT

Home Phone _____ Day Phone _____ Cell Phone _____

E-mail Address _____

Employer: _____ Employer Address: _____

What is or was your occupation? _____ ☐ Retired?

Name of Spouse/Parent/Legal Guardian _____ DOB _____ SSN _____

Primary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Is this visit covered by Workers' Comp? _____ No Fault? _____

Emergency Contact: _____ Phone #: _____

I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Comprehensive Allergy & Asthma Care's notice of privacy practice.**

Responsible Party Signature: _____ *Date:* _____

Patient Name: _____ DOB:_____ Date:_____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $50.00 may then be added to your account.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.
  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Comprehensive Allergy & Asthma Care, PLLC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Comprehesive Allergy & Asthma Care, PLLC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Comprehensive Allergy & Asthma Care, PLLC, will not be involved with separation or divorce disputes.

  You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment form you, you will be additionally responsible for whatever charges we incur as a result of this.

  WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

  THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____