The Allergy & Asthma Group, LLC

In order to serve you properly, we will need the following information. Please fill out completely: Please Print

Patient Name: _____ Age: _____ Birthdate: _____ (M) (F)

Address: _____ City: _____ State _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Soc. Sec. #: _____ Driver's License: State: _____ Number: _____

Email Address _____ **Preferred language** _____

Race _____ **Ethnicity** ☐ Hispanic ☐ Not Hispanic ☐ I prefer not to answer

Employer: _____ Address: _____ Phone: _____

Primary Physician: _____ Physician's Address: _____

Phone: _____ Pharmacy: _____ Pharmacy Phone: _____

Referred by: _____

Emergency Contact _____ Relationship _____ Phone _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR

Name: _____ Relation to patient _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employed by: _____ Employer Phone: _____

Driver's License #: State: _____ Number: _____

INSURANCE INFORMATION

Primary Insurance Company: Name of Insurance Company: _____

Address: _____ City: _____ State _____ Zip: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Relation to Patient: _____ (M) (F)

Date of Birth: _____ SS# _____

Policy #: _____ Group # _____

Office visit covered? Yes No Referral Needed? Yes No CoPay Amt _____

Secondary Insurance Company: Name of Company: _____

Address: _____ City: _____ State _____ Zip _____

Employer: _____ Address: _____ City _____ State ___ Zip _____

Policy Holder: _____ Relation to Patient: _____ (M) (F)

Date of Birth: _____ SS#: _____

Policy #: _____ Group # _____

Office visit covered? Yes No **Referral needed? Yes No** **CoPay Amt** _____

The information above is, to the best of my knowledge, accurate and current. I understand that I am financially responsible for all the charges whether or not paid by insurance. I am responsible for immediately informing the office of any charges in insurance coverage, and I will bear financial responsibility for lack of payment due to inaccurate information. _____ ((initials)

If my insurance requires referrals, I understand that I am responsible for obtaining the correct referral forms from my primary care physician. It is also my responsibility to keep them current. I accept financial responsibility for any service not paid due to lack of a referral. _____ (initials)

CONSENT FOR ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to The Allergy & Asthma Group, LLC for services provided. I authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided for the purpose of evaluating and administering claims of benefits.

Signature _____ Date _____

CONSENT TO TREAT

I, the undersigned as "patient" of being a person legally authorized to consent to services on behalf of the "patient" consent and authorize Linden D. Ho, M.D. and Michael Y. Viksman, M.D. to administer any treatment which may be deemed medically necessary for diagnosis and treatment.

Signature _____ Date _____

PAYMENT POLICIES

Copays are due at the time of service. Any copay that has to be billed will incur a $5.00 billing charge on each outstanding copay, each billing cycle.

Returned checks are subject to a $20,00 service fee. Checks will not be redeposited.

Signature of responsible party: Date: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION AND TREATMENT

Please list the person(s) to whom we may release medical information

_____

Please list any person who may bring your child for treatment _____

I understand we may revoke this consent in writing at any time.

Signature _____ Date _____

Relationship to Patient _____

NO SHOW AND CANCELLATION FEE

A 24-hour cancellation notice is required for all appointments. A $25 fee will be implemented if required notice is not given.

Signature _____ Date _____