Family Allergy Clinic

Richard A. Page, M.D.

PATIENT INFORMATION

(Please complete in full)

Date________________

Patient Name ______________________ Birth Date__________ Age________

Address______________________ City__________ State______ Zip________

Home phone # (______)______________ Cell phone # (______)______________

Name of Primary Physician ______________________ Phone # ______________

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widow Sex: ❍ M ❍ F

Patient/Guardian email ____

RESPONSIBLE PARTY:

Name______________________

Birth Date______________________

Occupation______________________

Employed by______________________

Business Phone______________________

Driver's License #______________________

Social Security #______________________

SPOUSE OF RESPONSIBLE PARTY:

Name______________________

Birth Date______________________

Occupation______________________

Employed by______________________

Business Phone______________________

Driver's License #______________________

Social Security #______________________

EMERGENCY CONTACT *(outside of own household)*

Name______________________ Relation______________

Address______________________ City__________ State______ Zip________

Daytime phone # (______)______________ Evening phone # (______)______________

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved by our staff ahead of time. We accept cash, check, MasterCard, Visa, American Express, Discover, and debit cards. We will be happy to submit your insurance claims for you and we accept assignment of benefits on all managed care programs that are contracted with us.

Returned checks are subject to a $25.00 fee.

We will gladly discuss fees for your proposed tests and treatment and will try to answer any questions relating to your insurance coverage.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and/or the insurance company. Any insurance benefits that we quote to you are not a guarantee of coverage or payment, only a quote of what we were told by your insurance company. Your insurance company may not pay exactly the way they quoted your benefits due to certain limitations they did not explain to us or because of an error in quotation on their part. **For whatever reason, if your insurance company does not pay, you will be responsible for all charges incurred with the exception of PPO and HMO discounts.**
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain **services they will not cover** and those charges **will be your responsibility.**
4. If a **pre-existing** is applied to your claim, those charges **will be your responsibility.**

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE ask us. We are here to help you.

____

Patient Date

TELEPHONE COMMUNICATIONS

Due to the Privacy Law, we need you to list the people (other than yourself) that you approve to have access to the following healthcare information: (If we may speak with anyone in your household, please note by writing "Anyone" in the appropriate blank.)

Appointment Scheduling Information:______________________________________

Billing Information:____

Lab Results/Test Results:____

Prescriptions/Medication Information:______________________________________

Authorization to Leave Messages

I authorize Family Allergy Clinic to leave messages regarding appointment reminders, my medical condition, such as lab reports, other test results, and medications on my home answering machine. This authorization will be in effect until I have given written notice to Family Allergy Clinic to the contrary.

Signature______________________________ Date:___________________________

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

HIPAA

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of FAMILY ALLERGY CLINIC, DR. RICHARD A. PAGE Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

____ ____________________

Patient Name (Type or Print) Date

____

Signature

REFERRALS

We want to know how you learned about us. Please mark any options that apply:

[] Our website [] Our sign [] Relative/Friend_______________

[] Physician________________ [] Phone book______________________________

[] Other:____