Family Allergy Clinic
Richard A. Page, M.D.

PATIENT INFORMATION

(Please complete in full)

Date: ________________
Patient Name ________________________________ Birth Date__________________ Age ________________
Sex: ◯ Male ◯Female Marital Status: ◯Child ◯Single ◯Married ◯Divorced ◯Widow
Address ____________________________________ City_________________ State__________ Zip__________
Home phone # (___)______________ Cell phone #(___)_____________ Work phone #(___)_______________
Primary Care Physician________________________________ Phone # (____)____________________________
Patient/Guardian email ____
Insurance Name/ID#______________________ Secondary Insurance Name/ID:___________________________

RESPONSIBLE PARTY IF UNDER 18:
Name___________________________________
Birth Date _______________________________
Address _________________________________
Relationship to patient ____________________
Cell phone _______________________________
Work Phone _______________________________

INSURANCE POLICY HOLDER:
Name ____
Birth Date ____
Address____
Relationship to patient ______________________________
Cell phone ____
Work phone _______________________________________

EMERGENCY CONTACT *(outside of own household)*
Name _________________________ Relationship _____________Daytime phone # ______________________

Please list non-guardians authorized to bring patient to Family Allergy Clinic for medical treatment:
Name ____________________________ Relationship _________________________ Phone (___)________________
Name ____________________________ Relationship _________________________ 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. We collect copay, deductibles and coinsurance at the time of service. 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 $32 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. **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 discount.**
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 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 are unable to keep your appointment, please cancel as far in advance as possible. We require a 24 hour cancelation notice. **Any no-show or late cancelation will be charged a $25 no-show fee**.

Patient/Guardian Signature **Date**

TELEPHONE COMMUNICATIONS

Due to the Privacy Law, we need you to list the people (other than yourself) that you approved 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 info: ____

Billing Information:____

Lab results/ Test results: ____

Prescription/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 voicemail. I authorize Family Allergy Clinic to send appointment reminders and billing information via my email if provided. 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

I hereby acknowledge that I have received or have been given 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 Privacy Practices.

Patient name: ____________________________________ Date: _________________________________

Signature: ____________________________________

Patient/Guardian Signature **Date**