ATLANTIC ALLERGY & ASTHMA CENTER, P.C.

PATIENT

Last Name _____ First Name _____ MI _____

Street _____ Date of Birth _____/_____/_____ Age _____

City _____ State _____ Last 4 digits Social Security ____ ____ ____ ____

Zip _____ (Male or Female) (Single, Married, Other)

Home Phone _____ Race(circle one) Asian Black Hispanic White

Cell Phone _____ Ethnicity(circle one) Latino Non-Latino

Pharmacy name _____ E-mail address _____

Pharmacy address_____ **Primary Physician _____**

Pharmacy phone number_____ Primary address _____

Occupation/Employer**?** _____ Primary phone:_____

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION

Mother's Name _____ Father's Name _____

Address _____ Address _____

Phone # _____ Phone # _____

Who is ***financially*** responsible for the minor? _____ or not applicable

INSURANCE

Primary Insurance Carrier _____

ID # _____

Group # _____

Policy Holder's Employer _____

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*Secondary Insurance Carrier*_____

*Secondary Policy Holder's Date of Birth*_____/____/_____

*Secondary Policy Holder's SS#*_____

Policy Holder/Guardian Name _____

Relationship _____

Policy Holder's Date of Birth _____/ _____/_____

Policy Holder's SS # _____

Policy Holder_____

Relationship_____

If Atlantic Allergy & Asthma Center must bill my insurance company for any services, I hereby request that payment of my benefits be made directly to the Atlantic Allergy & Asthma Center. I also authorize the release of any medical information needed to process this claim.

For allergy shot patients, I understand that in many instances, when I schedule my allergy injection appointment, the allergy serum will be prepared prior to my visit. I also understand and agree that in the event I do not keep my scheduled allergy injection visit, Atlantic Allergy & Asthma Center, P.C. will bill my insurance company for the pre-made allergy serum. If, for any reason, my insurance company does not pay incurred charges, I am fully responsible for payment. A copy of this can be considered as an original for insurance purposes.

If I do not pay the entire balance due (after my insurance company pays) within 25 days of the monthly billing date, a late charge of 1.5% on the balance unpaid and owed will be assessed each month. I understand that if a check given to our company "bounces" then a $25.00 fee will be applied to your account. I realize that failure to keep this account current may result in you being unable to provide services except for emergencies. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on the account or any future account balances. I also agree, in order for us to service your account or to collect any amounts you may owe, we or any billing/collection company associated with Atlantic Allergy & Asthma Center may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read and understand this disclosure and agree that I may be contacted as described above.

_____ _____

Signature of Patient (or guarantor) Date

Atlantic Allergy & Asthma Center, PC

CONSENT for LEAVING MESSAGES
CONSENT to LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY/FRIENDS

I understand that my healthcare information at Atlantic Allergy & Asthma Center, PC is protected and I have received a copy of their Notice of Privacy Practices. I understand as part of Atlantic Allergy & Asthma Center, PC's appointment process Atlantic Allergy & Asthma Center, PC will leave messages on my answering machine/voice mail/cell phone text message/family member regarding a reminder of an upcoming appointment

In order for Atlantic Allergy & Asthma Center, PC to leave more detailed messages on my voice mail or answering machine, I need to give permission to Atlantic Allergy & Asthma Center, PC to do so. If the patient is a minor(under the age of 18), then the below consents will still apply based on the signature of the guardian.

Consent for Leaving Messages

___ I consent to Atlantic Allergy & Asthma Center, PC to leave a message on my answering machine/voice mail/family member regarding the completion of any laboratory test results or radiology tests. I understand that if I am unavailable then Atlantic Allergy & Asthma Center, PC will leave a message for me to call back for further information. **I understand that information including the actual results of any laboratory or radiology test *will not* be left on the answering machine or voice mail.** I also understand that Atlantic Allergy & Asthma Center, PC will attempt a minimum of one telephone call with one left message regarding said result availability. I understand that it is my responsibility to call Atlantic Allergy & Asthma Center, PC regarding my results if the office has not called me within one week of getting any laboratory or radiology test performed. I understand that if I have not received a telephone call regarding my test results that it would indicate that Atlantic Allergy & Asthma Center, PC has not received any information from the laboratory or radiology facility and that a lack of a telephone call should not be construed as a normal test

___I do not want Atlantic Allergy & Asthma Center, PC to leave any messages on my answering machine regarding the availability of laboratory or radiology tests. I also understand it is my responsibility to call Atlantic Allergy & Asthma Center, PC regarding my results if I have not spoken with the office within one week of getting any laboratory or radiology test performed. I understand that if I have not received a telephone call regarding my test results that it would indicate that Atlantic Allergy & Asthma Center, PC has not received any information from the laboratory or radiology facility and that a lack of a telephone call should not be construed as a normal test.

Consent for Shared Information with Family & Friends

___ I do not want any healthcare information released to any family members

___ I wish family members(such as wife, husband, parent, etc) or friends to have access to my healthcare information. The name(s) listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the judgment of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

NAME	RELATIONSHIP
1. _____	_____
2. _____	_____
3. _____	_____

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

_____ _____
Patient Name **DOB**

_____ _____
Patient or Parent Signature (if patient is minor) **Date**