Date: ___________ **Chart #** _______________ **Patient Name:**____

Preferred Name: __________________ **Birth Date**: _____________ **Email**: _________________________________

Marital Status: ____ **Biological Sex:** ____ **Gender (circle)**: Male · Female · Non-Binary · Transgender: Male · Female

Home Address: _______________________________________ **City:** _______________ **State:** ______ **Zip:** ________

Mailing Address (if different than residential): ____

Pronouns: She/Her He/Him They/Them

Guarantor *(If patient is under 18 years of age and someone else is responsible for payment other than patient):*

Name____ Relationship __________________________

Address: ____ If same as above, please circle: YES

Home Phone ____________________ Cell Phone _________________ Work Phone __________________

Race (circle all that apply): American Indian/Alaska Native · Asian · Black/African-American
Native Hawaiian/Pacific Islander · White/Caucasian · Other: _______________________

Ethnicity: Hispanic/Latino · Non-Hispanic/Latino

Language: English · German · Spanish · Russian · ASL · Arabic · Korean · Other: _______________

<u>Preferred phone contact method (PLEASE CIRCLE ONE)</u>: *home cell work*

Home Phone:__________________________________ OK to leave detailed messages? (yes/no) _________

Cell Phone:____________________________________ OK to leave detailed messages? (yes/no) _________

Work Phone:___________________________________ OK to leave detailed messages? (yes/no) _________

(Optional): Employer: ___________________________ Occupation: ____________________________________

<u>Authorized persons who can discuss/obtain my personal health information:</u>

Name ____ Relationship ______________________

Name ____ Relationship ______________________

Name ____ Relationship ______________________

Emergency Contact__________________________________ Relationship___________________________

Home Phone __________________ Cell Phone___________________ Work Phone______________________

Referring Physician: ____________________________________ Phone # _________________________________

Address:____

Primary Care Physician:_________________________________ Phone # _________________________________

Address:____

Name/Location of Preferred Pharmacy ____

Date: _______________ **Chart #** ____________________ **Patient Name**___________________________________

Primary Insurance: ______________________ **ID#**_______________________**Group #**_______________

Claims Address:_______________________________________Phone # __________________________

Subscriber Name: _______________________________ Relationship: ______________ DOB___________

Secondary Insurance: ______________________ **ID#**_____________________**Group #**_______________

Claims Address:_______________________________________Phone # __________________________

Subscriber Name: _______________________________ Relationship: ______________ DOB___________

Allergy Clinic maintains a list of insurance companies that we bill automatically. Insurance claims are completed as a courtesy for you without charge. Allergy Clinic does not accept responsibility for collecting your claim unless you have an HMO. **COPAYMENTS ARE DUE AT THE TIME OF SERVICE.** In accordance with Allergy Clinic financial policy, all personal payments will be applied to the oldest outstanding balance first.

You are directly responsible to Allergy Clinic for payment of your account within thirty days of the billing date, regardless of the status of your insurance claim, unless you participate in PPO or HMO plan. You will receive up to two monthly billing statements. After sixty days unpaid balances may be transferred to a collection agency. Should your account be placed with collections we will expect all outstanding balances to be paid in full before additional services are rendered. In the event of extenuating circumstances rendering inability to pay please contact our billing personnel to discuss payment arrangements.

Each vial of serum contains antigens necessary for treatment and different patients require a different number of vials, dependent on your allergy status. There will be a separate charge to your insurance company for the serum, dependent on the number of vials required. The serum used for your desensitization is specifically prepared for you and cannot be returned to the manufacturer or used for any other patient.

IF YOU CONSENT TO BEGIN ALLERGY INJECTION THERAPY AND OPT NOT TO RETURN FOR TREATMENT, THE SERUM CHARGE WILL BE BILLED TO YOU PERSONALLY.

I authorize the release of any medical information necessary to process my claim. I authorize payment of medical benefits directly to Allergy Clinic. I understand I am financially responsible to Allergy Clinic for charges not covered by this assignment of benefits as well as those determined to be my responsibility by my HMO or PPO plan.
I understand the above credit policy and agree to accept responsibility for full payment of those charges determined by my insurance company to be my responsibility. If I do not have coverage in effect at the time when I incur charges, I agree to accept responsibility for full payment of my account.

I acknowledge and consent to the Notice of Privacy Practices. A copy is available upon request.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____________________________ DATE: _____________________

SIGNATURE OF ALLERGY CLINIC EMPLOYEE: ______________________________ DATE: _____________________