ALLERGY SPECIALTY CARE

213 SW Main Blvd. Lake City, FL 32025
(386) 961-9809 • Fax (386) 961-8311

PLEASE PRINT OR TYPE

Social Security # _____

Today's Date _____

Patient's Name_____
(Last) (First) (Middle)

Home Address _____
(Street) (City) (State) (Zip)

Age _____ Date Of Birth ____ / ___/ ___ Home Phone(_____)_____ Cell (_____) _____
(Month) (Day) (Year)

Patient's Employer _____ Phone(_____) _____

Spouse's Name _____ Phone(_____) _____ DOB _____

Address _____SS# _____

Employer _____ Phone(_____) _____

Person To Contact In Case Of Emergency _____

Relationship _____ Phone (_____) _____

*****IF PATIENT IS A MINOR OR YOUR PARENT IS RESPONSIBLE FOR INSURANCE, PLEASE FILL OUT THE FOLLOWING INFORMATION:**

Father's Name _____ Phone(_____) _____ Dob _____

Mailing Address _____SS# _____

Employer _____ Phone (_____) _____

Mother's Name _____ Phone(_____) _____ DOB _____

Mailing Address _____SS# _____

Employer _____ Phone (_____)_____

Referred By: _____ Phone (_____)_____

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Todays Date _____

Patient's Name _____ Age _____

Current Medications: _____

_____

_____

Chief Complaint/How Long:_____

_____

PLEASE CIRCLE YOUR ANSWERS TO THE FOLLOWING QUESTIONS:

NASAL: Stuffiness Sneezing Itching Runny Nose Loss of Smell
Polyps Mouth Breathing

NASAL DISCHARGE: Clear Colored Thick Watery

EYES: Itching Redness Swelling Discharge Watering Burning

DO YOU WEAR CONTACT LENSES: YES / NO

THROAT: Itching Drainage Hoarseness Loss of Voice Cough

SINUSES: Pain Fullness/Pressure Sinus Infections(How many per year____)

HEADACHES: YES / NO ***FREQUENCY:_____*** ***MIGRAINES:*** YES / NO

ARE SYMPTOMS SEASONAL OR YEAR-ROUND? _____

IF SO, WHAT MONTHS?_____

PAST SURGICAL TREATMENTS: NASAL / SINUS OTHER SURGERIES:_____

_____

OTHER CURRENT/PAST MEDICAL DIAGNOSES: _____

_____

SYMPTOMS ARE WORSENED OR BROUGHT ON BY:

Pollens Dust Pets Mowing Grass Cigarette Smoke Foods

Perfumes Changes in Weather Humidity Fumes(Chemical, Smog, Auto Exhaust, etc.)

CHEST SYMPTOMS? YES / NO

IF YES, HAVE YOU HAD - Trouble Breathing Wheezing Asthma Tightness in Chest

Bronchitis Frequent Cough Shortness of Breath of Wheezing with Exercise

SKIN SYMPTOMS: Rashes Hives Swelling Itching Eczema Contact Allergy Poison Ivy/Sumac

FAMILY HISTORY: (M-Mother, F-Father, S-Sister, B-Brother, C-Children) Food Allergy_____

Hayfever_____ Asthma_____ Eczema_____ Sinusitis_____

ENVIRONMENTAL HISTORY:

Your Present Residence is: House Apartment Dorm Mobile Home Other

Heating System: Central Heat Fireplace Wood Burning Stove Hot Water/Radiant Heat

Heating System: Central Air Window A/C

Are there any indoor pets? YES / NO ***IF YES, WHAT TYPE?*** _____

Flooring in Bedrooms: Carpeted Wood Linoleum Tile Other

Do you have: Feather Pillows Down Pillows Wool Blankets Down Comforter Humidifier

Stuffed Toys

What is your Occupation?_____

Does anyone at home smoke? YES / NO

Do you smoke (if an adult)? YES / NO

DRUG ALLERGIES: YES / NO TO WHAT? _____

_____

FOOD ALLERGIES: YES / NO TO WHAT? _____

_____

INSECT STING ALLERGIES: YES / NO TO WHAT? _____

PREVIOUS ALLERGY EVALUATION: YES / NO

HAVE YOU BEEN ON ALLERGY SHOTS IN THE PAST? YES / NO

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FINANCIAL POLICY

As your provider, we are committed to serving you with the best possible medical care. In order to achieve this goal, we need your assistance and understanding of our payment policy. We hope the following will help.

PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. Our office accepts cash, checks, Visa or MasterCard as payment. Returned checks are subject to a service charge of $25.00 or 5% of the face value, whichever is greater, and you will lose your privilege to write checks in our office. We understand that situations occur when it may be necessary to request us to bill you rather than paying at the time of service. We are able, at any time, to set up a payment plan. Don't hesitate to ask.

INSURANCE COVERAGE: Allergy Specialty Care is a participating provider in many healthcare plans. We also accept assignment for Medicare. As a courtesy to our patients, we will file your insurance claim. Co-payments and applicable deductibles are due and payable at the time of service. Checking on payment of claims is the patient's responsibility. Due to the number of insurance companies that we file, we are unable to keep track of every account. ***If you are on an HMO/ Managed Care insurance program, please verify with your primary care doctor that you have a current authorization number to see Allergy Specialty Care. If you do not have one, you will be responsible for the full amount of all office visits.**

CHILDREN OF DIVORCED PARENTS: Payment is due at time of service no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT: We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services that they will not cover.

We must emphasize that as your medical care provider, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** Collection actions will be taken on any account that is over 120 days, including those that insurance has not paid.

All monthly statements are due and payable upon receipt. It is your responsibility to keep the office informed of any changes in address, health insurance, primary physician and telephone number(s).

No question is too small for you to ask us, whether it is regarding your treatment, insurance or statement. We ask that you call or come by during our office hours. **WE ARE HERE TO HELP!**

Signature: _____ **Date:**_____

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AUTHORIZATION FOR INSURANCE ASSIGNMENT AND RELEASE OF INFORMATION

1. RELEASE OF INFORMATION

I authorize Allergy Specialty Care to release to any insurance company or governmental agency, (i.e.: BCBS, Medicare, Champus, etc.), any medical information contained in my records, when such material is required in connection with determining a claim for payment.

2. INSURANCE ASSIGNMENT

I authorize direct payment from any insurance company or governmental agency to Allergy Specialty Care for any medical benefits otherwise payable to me for services of Allergy Specialty Care, but not to exceed the reasonable and customary charges for these services. I authorize payment as a direct assignment of my rights and benefits under my insurance policy, and I instruct and direct my insurance carrier to pay by check made out and mailed to: Allergy Specialty Care 213 SW Main Blvd. Lake City, FL 32025.

3. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance or third payor within a reasonable period of time.

SIGNATURE: _____

Insured or Authorized Person's Signature

DATE: _____

ORIGINAL SIGNATURE ON FILE AT PROVIDER'S OFFICE

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CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to ALLERGY SPECIALTY CARE and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting us at 386-961-9809

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign:_____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____