ADVANCED ALLERGY & ASTHMA

Kumar Patel, M.D.

Leah Hogan, CRNP **Christopher J. Foti, PA-C**

PATIENT IDENTIFICATION: PLEASE PRINT AND FILL OUT ENTIRE FORM

Patient Name (first, middle initial, last)____________________

Age ____________ Date of Birth ______________

Address____________________

Home Phone #____________________ Cell Phone #____________________

Email Address____________________ Marital Status____________________

Patient's Occupation____________________ Work #____________________

Employer's Name____________________ SS #____________________

Person to Notify (Name/Phone # of Relative/Friend NOT residing with you)____________________

____

Referring Physician (Name/Address/Phone #)____________________

____

PCP (Name/Address/Phone #)____________________

Pharmacy (Name/Phone #)____________________

FINANCIAL RESPONSIBILITY:

Name____________________ Relationship ____________________

Address (if different than above)____________________

Phone # (if different than above)____________________

Date of Birth______________

INSURANCE INFORMATION:

Name of Insurance Company____________________

Address____________________ Phone #____________________

Identification #____________________ Group #____________________

Policy Holder's Name____________________ Relationship____________________

Secondary Insurance____________________

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I understand that payment of copays incurred is due at the time of services. I further agree to pay all reasonable attorney fees and collection costs in the event of a default of payment on my account. I further authorize and request that insurance payments be made directly to Advanced Allergy & Asthma/Dr. Kumar Patel. I have read and fully understand the above, consent for treatment, financial responsibility, release of medical information and insurance authorization.

____________________ ____________________

Signature of Patient/Parent/Guardian Date

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I, ________________________________, give permission to Advanced Allergy & Asthma to leave information on an answering machine. I understand this may pertain to medical information.

______________________________ ______________

Signature Date

I also give permission for the following people to be given information:
(Please check all that apply)

- ☐ Spouse: Name______________________________
- ☐ Mother: Name______________________________
- ☐ Father: Name______________________________
- ☐ Children: Name(s)____________________________
- ☐ Grandparents: Name(s)____________________________
- ☐ Other: Name(s)____________________________
  Relationship__________________________

______________________________ ______________

Signature Date

May we have permission to contact you at your place of employment? Yes or No
If yes, please provide the phone number. __________________________

______________________________ ______________

Signature Date

KUMAR PATEL, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices/Consent to Treat

Dr. Kumar Patel has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer:

Dr. Kumar Patel
Attention: Privacy Officer
301 East Fifth Avenue
Tarentum, PA 15084
724-224-5440

Acknowledgement of Receipt and Consent to Treat

I, ______________________________________, give my consent to practitioners of Dr. Patel, Allergy & Asthma, to perform medical services determined to be necessary or advisable for the benefit of my health care. I acknowledge that I have received the Notice of Privacy Practices for Dr. Patel, Allergy & Asthma. Dr. Patel, Allergy & Asthma, is authorized to use and disclose my protected health information for treatment, payment, and health care operation purposes with its Notice of Privacy Practices.

Medicare Certification

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of any protected health information about me to release to the Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or organization to submit a claim to Medicare for payment to me.

____
Name of Patient

______________________________________ ____________________
Signature of Patient/Guardian Date

______________________________________ ____________________
Name of Guardian Relationship

Good Faith Efforts to Obtain Acknowledgement of Receipt

The above named patient/guardian was offered the Notice of privacy Practices.
Describe how notice was provided:

- ☐ Offered copy and individual refused to accept delivery.
- ☐ Offered copy and individual accepted delivery.
- ☐ Other ____

Describe efforts to obtain signature on acknowledgement of notice form:

- ☐ Patient/guardian was asked to sign form and refused.
- ☐ Other ____

______________________________________ ____________________
Signature of Staff Member Date