PATIENT INFORMATION AND AUTHORIZATIONS

NAME OF PATIENT _____M_____F_____

ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE ( )_____ CELL PHONE ( )_____ DAYTIME PHONE ( ) _____

DOB _____ AGE _____ SS# _____ HEIGHT _____ WEIGHT _____

OCCUPATION _____ EMPLOYER _____

SPOUSE'S NAME _____ DOB _____ SS# _____

GUARDIAN/PARENT (IF PATIENT IS A MINOR): _____

REFERRED BY: PHYSICIAN: DR. _____ OTHER _____

IF YOU WERE NOT REFERRED, HOW DID YOU LEARN ABOUT US? _____

NAME OF PERSONS AUTHORIZED TO DISCUSS YOUR PERSONAL HEALTH INFORMATION WITH US:

NAME _____ Ph# _____ NAME _____ Ph# _____

INFORMATION PERTAINING TO PERSON FINANCIALLY RESPONSIBLE IF OTHER THAN THE PATIENT:

NAME: _____ DOB _____ SS# _____

ADDRESS _____HOME PHONE _____

EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS:_____CITY: _____

STATE _____ ZIP _____ HOME PHONE ( )_____ CELL PHONE ( ) _____

NAME OF FAMILY MEMBERS WHO ARE PATIENTS HERE:

NAME _____ NAME _____

NAME OF PRIMARY INSURANCE CARRIER: _____ EMPLOYER _____

POLICYHOLDER'S NAME: _____ RELATIONSHIP TO PATIENT _____

DOB _____ ID#: _____ GROUP #_____

DEDUCTIBLE AMOUNT _____ CO-PAY AMOUNT _____ OR PERCENT_____

NAME OF SECONDARY INSURANCE CARRIER _____ EMPLOYER _____

POLICYHOLDER'S NAME _____ DOB _____ RELATIONSHIP TO PATIENT _____

ID# _____ GROUP # _____ DEDUCTIBLE AMOUNT: _____ COPAY AMOUNT _____

I have read a copy of The Asthma, Allergy & Sinus Clinic Notice regarding Privacy of Personal Health Information. I am aware that I may request a copy of the Notice at any time. I authorize any holder of medical or other information, including personal health information about me to release to the Social Security Administration or its intermediaries, or carriers for Medicare claims, or to my insurance company or its representative, any information needed to process any insurance claims. I authorize The Asthma, Allergy & Sinus Clinic (TAASC) to delegate inspection of my personal health information for the purpose of determining if I may be a candidate for a potential new medication or research study. Such inspection may be conducted by a research organization not related to The Asthma, Allergy & Sinus Clinic. I further understand that it is the policy of TAASC to obtain payment for services rendered in a timely manner. I also understand that insurance payment may constitute a portion and not the whole of the payment owed to TAASC. Failure to fulfill the obligation to pay my portion of the bills in a timely manner will result in my account to be turned over to a collection agency. In that event, I understand that I will be responsible for any additional charges by the collection agency. I understand that it is the policy of TAASC to charge for missed appointments, unless cancellation was received at least 24 hrs in advance. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefit either to myself or to the party who accepts assignment. I authorize TAASC and Roberto Di Nicolo, MD to obtain or release to, any medical records, test results, reports, from and to any other medical providers, hospitals, labs, x-ray facilities, as requested by my medical care. All authorizations shall never expire, unless revoked in writing.

DATE: _____ SIGNATURE OF PATIENT/PARENT/GUARDIAN:_____