Allergy A.R.T.S.
Asthma, Rheumatology Treatment Specialists

Patient Registration

Patient's Name:_____ SS #: _____
First Name MI Last Name

Date of Birth:_____ ☐Male ☐Female ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Language: ☐English ☐Other,_____ Race: ☐White ☐Black or African American ☐Hispanic ☐Other _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other or Undetermined

Street Address :_____

City/State/Zip Code:_____ Home Phone w/Area Code:_____

Cell Phone w/Area Code:_____ Fax w/Area Code:_____

Spouse's Name:_____ SS #:_____

Spouse's Employer:_____ Spouse's Work Phone #:_____

Patient's Employer:_____ Work Phone w/Area Code:_____

Credit: (Circle) MC Visa #_____ Exp ___/___/___ Name on card_____

Responsible Party:_____ Relationship: ☐Self ☐Spouse ☐Parent ☐Other:_____

If patient is a Minor, are parents ☐Married ☐Divorced Custodial Parent:_____

Custodial Parent's Home Phone w/Area Code:_____ Work Phone w/Area Code:_____

Custodial Parent's SS #:_____ Date of Birth:_____

In case of emergency, contact (not living with you):_____

Phone Number w/Area Code:_____ Relationship to Patient:_____

Referring Physician's Name & Phone Number:_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ Phone Number:_____

>>Primary Insured's Name:_____ >>Date of Birth:_____

Policy #:_____Group #:_____ Relationship:_____

Insurance Company # 2:_____ Phone Number:_____

>>Primary Insured's Name:_____ >>Date of Birth:_____

Policy #:_____ Group #:_____ Relationship:_____

- I hereby authorize the payment of medical benefits to ALLERGY ARTS, LLP for services rendered and all future claims. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize ALLERGY ARTS, LLP to release any medical information necessary to complete and process my insurance claims.

>>_____ _____
>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

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Billing Policy

The following sets forth the general billing policy of ALLERGY ARTS, LLP Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of ALLERGY ARTS, LLP with current, accurate billing information at the time of check in and to notify ALLERGY ARTS, LLP of any changes in this information.

- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

- I understand that there is a $25 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the $25 fee (payable prior to completion) is required.

- I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any office visit. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated procedures/services to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

- I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

- If you are unable to make your appointment, YOU MUST NOTIFY THE CLINIC AT LEAST 24 HOURS IN ADVANCE AND RESCHEDULE YOUR APPOINTMENT. You will be considered for termination from the practice once you have multiple no-show appointments.

My signature below confirms that I have read the billing policies. I understand and agree to this Financial Policy.

_____ _____

Legal Signature Date

_____

Relationship to Patient