ALL SEASONS ALLERGY, ASTHMA AND IMMUNOLOGY CENTER
ADULT PATIENT INFORMATION

PATIENT'S NAME _____ **NICKNAME** _____

SEX: MALE FEMALE **DATE OF BIRTH** _____/_____/_____ **EMAIL** _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ EMPLOYED BY: _____

CELL PHONE _____ OCCUPATION _____

WORK PHONE _____ BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____

DATE OF BIRTH _____/_____/_____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ EMPLOYED BY: _____

CELL PHONE _____ OCCUPATION _____

WORK PHONE _____ BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP

GENERAL CONSENT FOR MEDICAL TREATMENT:

I, KNOWING THAT I AM SUFFERING FROM A CONDITION REQUIRING DIAGNOSTIC, MEDICAL OR SURGICAL TREATMENT DO HEREBY VOLUNTARILY CONSENT TO SUCH PROCEDURES AND CARE AND TO SUCH MEDICAL SURGICAL OR OTHER SERVICES UNDER THE GENERAL AND SPECIFIC INSTRUCTIONS OF STEPHEN E. MILES, M.D., HIS ASSISTANTS OR HIS DESIGNEE AS IS NECESSARY IN HIS JUDGEMENT. I ALSO ACKNOWLEDGE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENTS OR EXAMINATION BY STEPHEN E. MILES, M.D.

FINANCIAL RESPONSIBILITY AGREEMENT:

ALLERGY EVALUATION INCLUDING SKIN TESTING AND/OR ANY OTHER SERVICES PERFORMED BY THIS OFFICE ARE SUBJECT TO PAYMENT IN FULL AT TIME OF SERVICE. AS A COURTESY TO OUR PATIENTS, OUR OFFICE WILL FILE ON YOUR INSURANCE PROVIDED ALL INSURANCE INFORMATION AND FORMS ARE FURNISHED. ALL OTHER ARRANGEMENTS FOR PAYMENT MUST BE MADE IN ADVANCE. PLEASE GIVE THE OFFICE A TWENTY-FOUR HOUR NOTICE TO CANCEL AN APPOINTMENT. AS A COURTESY TO OUR OTHER PATIENTS, IT IS IMPORTANT THAT YOU BE ON TIME FOR YOUR APPOINTMENT. I HAVE READ THE ABOVE OFFICE POLICY REGARDING PROFESSIONAL FEES AND SERVICES AND ACCEPT RESPONSIBILITY FOR PAYMENT OR SERVICES RENDERED. LIST PERSON RESPONSIBLE FOR BILLING _____.

NO SHOW POLICY: ***A $40.00 CHARGE*** ***WILL BE ASSESSED*** **FOR ALL MISSED OR RESCHEDULED APPOINTMENTS WITHOUT A 24-HOUR NOTICE. THREE MISSED APPOINTMENTS WITHOUT NOTIFICATION WILL RESULT IN TERMINATION OF THE PATIENT/DOCTOR RELATIONSHIP.**

_____ _____

SIGNATURE **DATE**