All Seasons Allergy

Office: 281-363-3508 | Fax: 281-298-7787
www.allseasonsallergy.com

Patient Information

Patient's Last Name:	First:	MI:	Social Security Number:
Birth Date:	Age:	Sex:	Ethnicity:
Street Address:			
City:	State:	ZIP Code:	
Home Phone:	Cell Phone:	Work Phone:	
E-Mail Address:	Employer or Student Status:		
Referring Physician Name:	Primary Care Physician Name:		

Emergency Contact

Emergency Contact Name:	Relationship:	Phone:

Primary Insurance / Secondary Insurance

Primary Insurance		Secondary Insurance	
Carrier:	Cardholder's Name:	Carrier:	Cardholder's Name:
Relationship to Patient:	Cardholder's Birth Date:	Relationship to Patient:	Cardholder's Birth Date:
Cardholder's Social Security Number:		Cardholder's Social Security Number:	
Identification Number:		Identification Number:	

Pharmacy Information

Preferred Pharmacy Name :	Phone:	Address or Intersection:

Medical Release

I hereby authorize the release of my medical records to the following individuals:

Name:	Relationship:	Date:
Name :	Relationship:	Date:

Office visit co-pays or deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage. My signature below confirms that the information provided is accurate and complete to the best of my knowledge. I consent to the performance of diagnostic procedures, examinations, and rendering of treatment that the medical provider and designated medical staff as it is deemed necessary in the medical provider's best judgment.

Signature of Patient or Responsible Party:	Date:

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Financial Policies

Because of our commitment to provide you with the highest standard of medical care, please be aware of our financial policies concerning payment of your medical expenses.

Please Review This Notice Carefully

1. Payment

Payment for services is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept Visa, MasterCard, Discover, American Express, cash, or check. The patient is responsible for all co-payment, co-insurance, or deductible amounts as assigned by the insurance carrier. If our office cannot verify insurance benefits, payment is due in full when you check-in for your appointment. If you are waiting for coverage to become effective or have no medical insurance coverage, payment in full will be expected the day you are seen. Patients must promptly inform the office of a change in insurance coverage.

2. Insurance

Your insurance is an agreement between you and your insurance company. As a courtesy to our patients, we will file insurance claims on all visits with our providers.
You should check with your insurance company to be certain of our provider status. If we are not providers for your insurance plan, you will be required to pay for your services at the time of your appointment.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the charge. Payment is due upon receipt of a statement from our office. We highly recommend that you read your insurance booklet or a copy of the insurance contract to determine your benefits.

You are required to be aware whether your insurance company required a referral and obtaining the referral before you are scheduled with one of our providers. Referrals typically have an expiration date and a limited number of visits. It is your responsibility to monitor expiration dates and number of visits.

Our providers may request certain tests and evaluations to further diagnose and treat your condition. We will assist you in making arrangements for tests and evaluations we require, but you are responsible for informing us of the facilities that are on your insurance plan. Failure to do so may result in charges to you by other facilities that your insurance does not cover.

You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable immediately. Be prepared to present your insurance card at each visit.

You will be responsible for notifying the office of a change of address, telephone number, and/or insurance information.

3. Returned checks

There is a **$35 service fee** on all returned checks in addition to the amount of the check. NSF (non-sufficient funds) checks must be redeemed with certified funds (cashier's check, credit card, money order, certified check, or cash) at or before the next office visit.

4. Past due accounts

Patients who have not made an effort to make payment arrangements to meet their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned to a collection agency will be expected to satisfy their financial obligation and pay for any future services in advance.

My signature below acknowledges that I have read All Season Allergy's financial policies and agree to its terms.

Patient Name:	Date of Birth:
Signature of Patient or Responsible Party:	Date:

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Patient Authorization for E-Mail and SMS Text Communication

All Seasons Allergy will use e-mail and SMS text messages for appointment reminders and emergency purposes only.

E-mail communications from All Seasons Allergy are on an un-encrypted server and the security of such e-mails cannot be guaranteed. Furthermore, All Seasons Allergy is not responsible for e-mails reaching any unintended recipients.

I will inform All Seasons Allergy of any changes of e-mail address or phone number.

I understand that I may be charged for calls or SMS texts by my wireless carrier.

My signature below acknowledges that I have read All Seasons Allergy's Authorization for E-mail and SMS Text Communication and consent to receiving such communication.

Patient Name:	Date of Birth:
Signature of Patient or Responsible Party:	Date: