ALLERGY AND ASTHMA CARE, P.A.

12000 ELM CREEK BLVD. #360
MAPLE GROVE, MN 55369
TEL (763) 420-1010 FAX (763) 420-3710

DATE: _____

LEGAL NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip Code

DATE OF BIRTH:	AGE:	GENDER: M ( ) F ( )	MARITAL STATUS S ( ) M ( ) SEP ( ) D ( ) W ( )
HOME PHONE:	OTHER/CELL PHONE:		IS IT OK TO LEAVE A MESSAGE ON YOUR VOICE MAIL ( ) YES ( ) NO
E-MAIL ADDRESS:			
SOCIAL SECURITY #:	PRIMARY LANGUAGE:		RACE:

PRIMARY CARE PHYSICIAN: _____ **CLINIC NAME:** _____

REFERRED BY: _____ CLINIC NAME: _____

PHARMACY NAME/ CITY _____

IN CASE OF EMERGENCY, NOTIFY (list name, Relationship & number):

***PLEASE FILL OUT SECTION COMPLETELY ***		PRIMARY INSURANCE COMPANY:
ID OR POLICY #:		GROUP #:
NAME OF POLICY HOLDER: RELATIONSHIP TO PATIENT:	POLICY HOLDER DOB:	**Please provide address of policy holder if different than the patients**
SECONDARY INSURANCE COMPANY:		
ID OR POLICY #:		GROUP #:
NAME OF POLICY HOLDER: RELATIONSHIP TO PATIENT:	POLICY HOLDER DOB:	**Please provide address of policy holder if different than the patients**

IF PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION COMPLETELY

NAME OF RESPONSIBLE PARTY FOR PAYMENT:	RELATIONSHIP TO PATIENT:	
ADDRESS OF RESPONSIBLE PARTY FOR PAYMENT:	PHONE # OF RESPONSIBLE PARTY FOR PAYMENT:	
MOTHER'S NAME:	DOB:	HOME PHONE:
HOME ADDRESS:		
FATHER'S NAME:	DOB:	HOME PHONE:
HOME ADDRESS:		

CO-PAYMENTS: Co-payments are due at the time of service.

REFERRALS: If your insurance requires a referral, please obtain this referral prior to receiving care at Allergy And Asthma Care, P.A. by calling your primary physician or health plan. This will ensure your eligibility for maximum coverage by your plan. Information regarding referrals may be included on your identification card.

Please present current insurance information at the time of service. Please remember that you are ultimately responsible for any balance that your insurance plan does not cover. We cannot guarantee the amounts of coverage offered by your insurance carrier, as each policy is different.

CREDIT POLICY AND PATIENT RESPONSIBILITY: It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. It is your responsibility to know your insurance coverage. In the event your account becomes past due and is referred to an outside agency, you will be responsible for the collection costs along with any reasonable attorney fees.

A **FINANCE CHARGE** of 1.5% per month, 18% per year, may be imposed on any balance over 90 days old. We would be happy to assist you and your family in any way we can. Should you encounter any difficulties, please notify us as soon as possible to avoid any misunderstanding regarding your account.

PAYMENT AUTHORIZATION/RELEASE OF RECORDS

I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE COMPANY TO ALLERGY AND ASTHMA CARE, P.A.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS AS NECESSARY TO MY INSURANCE COMPANY OR ANOTHER PHYSICIAN OR ANOTHER PARTY OF MY DESIGNATION FROM ALLERGY AND ASTHMA CARE, P.A.

To the best of my knowledge, I have completed the patient portion of this form, and I have read and understand my financial obligation and patient responsibility.

A signature must be on file in order to release your medical records to an insurance company or physician. Per state law, this authorization automatically expires in 12 months at which point we may find it necessary to have you complete another form.

I acknowledge that I have been offered a copy of Allergy and Asthma Care, PA's Notice Regarding Privacy of Personal Health Information. If I would like a copy in the future, I will ask for one.

Signature of Insured _____ **Date**_____

Responsible party (if minor) _____**Date**_____

AUTHORIZATION TO SPEAK TO SPOUSE/RELATIVE/FRIEND

If I am not available, I authorize the following individual to discuss: My Bill ( ) My Medical Care ( )

_____ _____ _____

Authorized Individual **Relationship** **Date**

_____ _____

Patient Signature **Date**

Updated 12/18 GK