4194 Royal Pine Drive, Colorado Springs CO 80920
Phone: 719-344-5355 Fax: 844-266-5420

ALLIGATOR ALLERGY & ASTHMA

DEMOGRAPHICS

Patient Name & Parent/Guardian if <18y/o:	
Date Of Birth:	Patient SSN:
Home Phone:	Cell Phone:
Address:	
Email Address:	
Primary Care Physician/Facility:	
Gastroenterologist (GI) and Location:	
Previous Allergist and Location:	
Preferred Pharmacy:	
Pharmacy Location:	

Insurance Name (OR Self Pay):	
Policy Holder's Name:	
Member ID#:	Group #:
Guarantor (responsible party paying for medical care):	
Guarantor Address:	
Guarantor DOB:	Guarantor SSN:
Guarantor's Relationship to Patient:	
TRICARE MEMBERS ONLY, Sponsor's SSN:	
TRICARE MEMBERS ONLY, DOD BENEFITS#:	
Emergency Contact Name:	
Relationship to Patient:	
Phone:	Additional Phone:
I authorize Alligator Allergy and Asthma to discuss medical and/or financial information with this person:	Y N

PLEASE SEE BACK OF SHEET FOR FINANCIAL POLICY

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PAYMENT POLICY

- **For Self-Pay, payment is due in full on the day service is rendered.**
- **For Insured, Copay is due at time of visit.**
- **Cash, Check, Visa and MasterCard accepted.**
- **There will be a $50 charge for no-show appointments/cancellation with less than 24 hrs notice.**

INSURED PATIENTS:

- Your copay, coinsurance and deductible is required at the time of service. Please keep in mind that insurance companies require us to collect these at time of service.
- If you would like to defer Payment in full until after your insurer pays their portion, then we can accept a credit card to be kept securely on file; charges will not be applied until after we receive notification of payment by your insurer.
- While we do our best to determine the amount due at the time of the visit, it is ultimately your responsibility to know your co-payment, co-insurance, and deductible balance. This includes being aware of policy limits on allergy testing and treatment. You are responsible for charges beyond what your policy's limits set for these services.

SELF-PAY PATIENTS:

- If you are paying for services out-of-pocket on the day of service; i.e., without an insurer involved, then you can take advantage of our substantial 'prompt pay' discount. The prices are published on our website or are available in the office upon request.
- If you cannot pay in full on the day of service, then we will accept a credit card to be kept securely on file and apply charges in 30 days if payment is not received in the interim.

BALANCE DUE:

- Payment plans can be discussed for balances due with our billing personnel.
- Unpaid balances after 90 days will automatically be referred to a collection agency without notification. You will be responsible for collection costs which are incurred. If your account is in a collection status, the balance must be paid in full prior to further services being rendered.
- Returned checks will incur a $30 fee to the existing balance due.

Any discrepancies to this payment policy, please inquire with the billing personnel prior to signing and initialling below.

____ I HAVE READ AND AGREED WITH THE ABOVE PAYMENT POLICY FOR MEDICAL SERVICES THAT WILL BE PROVIDED.

____ I AGREE TO ELECTRONIC COMMUNICATION (E.G. EMAIL) OF MEDICAL RECOMMENDATIONS, STATEMENTS, APPOINTMENT REMINDERS, ETC. FROM THIS OFFICE.

____ I CERTIFY THAT I DO NOT PARTICIPATE IN THE MEDICAID PROGRAM AS PRIMARY OR SECONDARY COVERAGE. AA WILL NOT BILL MEDICAID UNDER ANY CIRCUMSTANCES.

____

Patient/Parent/Guardian Name: **Signature:** **Date:**