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:	
Other Specialist and Location:	
Preferred 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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ALLIGATOR ALLERGY & ASTHMA

PAYMENT POLICY 2022

- **There will be a $50 charge for no-show appointments/cancellation with less than 24 hrs notice.**
- **Cash, Check, Visa, MasterCard and American Express accepted.**

INSURED PATIENTS:

- Your copay is required at the time of service.
- You authorize your insurance to pay Alligator Allergy directly for services rendered.
- Payment is due in full 30 days after your insurer processes your claim. You will receive a statement for your balance due.
- It is your responsibility to know your co-payment, co-insurance, and deductible balance, as well as any 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:

- Payment is due in full on the day service is rendered.
- Payment arrangements must be discussed with our billing personnel **before** service is rendered if you cannot pay in full on the day of service.
- 'Prompt Pay' fee schedule is available upon request.

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 any collection costs 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 in addition to the existing balance due.

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

____ I have read and agree with the above payment policy for medical services that will be provided.

____ I agree to receive electronic communication (email and/or text) of medical recommendations, statements, appointment reminders, etc. from this office.

____ I authorize the release of any medical information needed to process my claim.

____ I certify that I DO NOT participate in the Medicaid program as primary or secondary coverage. AA will NOT bill Medicaid under any circumstances.

Printed Patient Name: **Authorized Signature:** **Date:**