4194 Royal Pine Drive, Colorado Springs CO 80920
Phone: 719-344-5355 Fax: 844-269-5420

ALLIGATOR ALLERGY & ASTHMA

DEMOGRAPHICS	
Patient Name & Parent/Guardian if <18y/o:	
Date Of Birth:	Patient SSN:
Home Phone:	Cell Phone:
Address:	
Email Address:	
Preferred Pharmacy/Location:	
Primary Care Physician/Facility:	
Previous Allergist and Location:	
Other Specialist and Location: (ie Gastroenterology, ENT, Dermatology, Rheumatology, etc)	

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:	Email Address:
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

FINANCIAL POLICY 2024

- **There will be a $50 charge for no-show appointments/cancellation with less than 48 hrs notice.**
- **Cash, Check, Visa, MasterCard and American Express accepted.**

INSURED PATIENTS:

- You are responsible for knowing your insurance's network status with our office and whether a referral is required by your plan for a specialist. If a referral is required, you are responsible for obtaining one from your primary care provider or from your insurance.
- 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 status, 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 and for any services deemed not medically necessary by your insurance.
- It is your responsibility to know what lab or imaging center is in-network with your insurance before having any testing performed.
- If you have an insurance change, you MUST notify our office immediately. Any charges not covered because of an unannounced insurance change will be your responsibility.

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 initialing below.

____ I certify that I DO NOT participate in the Medicaid program as primary or secondary coverage. AA will NOT bill Medicaid under any circumstances, and your benefits will be at risk if you receive care in this office..

____ 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.

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