|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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: |  |  |  |  |  |

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| 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 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:** |