

Birmingham Allergy and Asthma Specialists, PC

Today's Date: ___/___/_____

Date of Visit: ___/___/_____

Physician: _____ Dr. Carol Smith

_____ Dr. Clara Chung (please check one)

Referred by: _____

PATIENT INFORMATION				
CLINIC ID # (for internal use)	PATIENT NAME: First	Middle	Last	SEX
				DATE OF BIRTH ___/___/_____
PATIENT HOME ADDRESS (include city, state, zip)			PATIENT HOME PHONE	PATIENT CELL PHONE
E-MAIL ADDRESS	PATIENT'S SOC. SEC. # ____-____-_____	RELATIONSHIP STATUS [] Single [] Married [] Div. [] Wid. [] Other		ETHNIC ORIGIN (optional)
PATIENT EMPLOYER NAME & ADDRESS			PATIENT WORK TELEPHONE	OCCUPATION

IF PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING INFORMATION			
NAME OF LEGAL GUARDIAN (Mother/Father)	HOME PHONE	CELL PHONE	WORK PHONE
NAME OF LEGAL GUARDIAN (Mother/Father)	HOME PHONE	CELL PHONE	WORK PHONE

RESPONSIBLE PARTY (Person who is financially responsible for the clinic bill)		
RESPONSIBLE PARTY: First	Middle	Last
		RESP. PARTY SOC. SEC. # ____-____-_____
RESPONSIBLE PARTY HOME ADDRESS (include city, state, zip)		RESP. PARTY DATE OF BIRTH ___/___/_____
RESPONSIBLE PARTY HOME TELEPHONE	RESPONSIBLE PARTY CELL PHONE	RESPONSIBLE PARTY WORK PHONE
RELATIONSHIP OF RESPONSIBLE PARTY to PATIENT (check only one)		
<input type="checkbox"/> Self <input type="checkbox"/> Stepmother <input type="checkbox"/> Spouse <input type="checkbox"/> Child-insured has no financial resp <input type="checkbox"/> Child <input type="checkbox"/> Mother <input type="checkbox"/> Stepfather <input type="checkbox"/> Life Partner <input type="checkbox"/> Ward of State <input type="checkbox"/> Employee <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Significant Other <input type="checkbox"/> Emancipated Minor Child <input type="checkbox"/> Other Relationship		

RESPONSIBLE PARTY EMPLOYMENT	
<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Other	
RESPONSIBLE PARTY EMPLOYER NAME	EMPLOYER TELEPHONE
RESPONSIBLE PARTY EMPLOYER ADDRESS (include city, state, zip)	

EMERGENCY CONTACT (Please list someone not living at same address)		
EMERGENCY CONTACT NAME (1)	RELATIONSHIP TO PATIENT	ADDRESS
HOME PHONE	CELL PHONE	WORK PHONE
EMERGENCY CONTACT NAME (2)	RELATIONSHIP TO PATIENT	ADDRESS
HOME PHONE	CELL PHONE	WORK PHONE

INSURANCE INFORMATION (Please provide your current insurance card(s) and/or referral information)				
PRIMARY INSURANCE COMPANY	SUBSCRIBER NAME	SUBSCRIBER EMPLOYER		
ID NUMBER	GROUP NUMBER	EFFECTIVE DATE ___/___/_____	END DATE ___/___/_____	SUBSCRIBER DATE OF BIRTH ___/___/_____
RELATIONSHIP OF RESPONSIBLE PARTY to PATIENT (check only one)				
<input type="checkbox"/> Self <input type="checkbox"/> Stepmother <input type="checkbox"/> Spouse <input type="checkbox"/> Child-insured has no financial resp <input type="checkbox"/> Child <input type="checkbox"/> Mother <input type="checkbox"/> Stepfather <input type="checkbox"/> Life Partner <input type="checkbox"/> Ward of State <input type="checkbox"/> Employee <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Significant Other <input type="checkbox"/> Emancipated Minor Child <input type="checkbox"/> Other Relationship				
SECONDARY INSURANCE COMPANY	SUBSCRIBER NAME	SUBSCRIBER EMPLOYER		
ID NUMBER	GROUP NUMBER	EFFECTIVE DATE ___/___/_____	END DATE ___/___/_____	SUBSCRIBER DATE OF BIRTH ___/___/_____

IF PATIENT IS TRANSFERRING CARE TO OUR OFFICE, NAME OF PREVIOUS PROVIDER/CLINIC: _____

HOW DID YOU LEARN ABOUT OUR PRACTICE

Newspaper/Ad: _____
 Employer
 Clinic Brochure
 Insurance Company
 Website

Referring MD: _____
 Other: _____
 Yellow Pages

Friend: _____
 Relative: _____

**Authorization to Release Information
And to
Pay Benefits to Provider**
Please Read and Sign Below

A photocopy of this authorization may be used in place of the original.

I hereby authorize Birmingham Allergy & Asthma Specialists, PC to release any medical or patient information acquired in the course of my examination to the insurance carrier(s)/Center for Medicare and Medicaid Services and its agents needed to determine these benefits payable for related services. I also authorize release of my medical information related to my symptoms/treatment to other health care providers when my provider refers me to them for specialty services.

In addition, I also hereby authorize payment of authorized insurance/Medicare benefits be made directly to Birmingham Allergy & Asthma Specialists, PC for the medical/surgical benefits if any, otherwise payable to me for his/her services. I understand the clinic charges may exceed insurance company/Medicare payment, and if greater than such, I will be responsible for paying that additional allowable amount.

I agree to pay for charges which may not be covered by my insurance. I understand that the following services may not be covered:

As specified, I understand that, at any time, I may revoke this authorization of the release of my medical records. If I revoke this authorization, however, there may be difficulties in obtaining insurance payment for my treatment. In any event, I will assume complete responsibility for payment of all charges.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done.

I understand, whether I sign as an agent or as a patient, that whatever services are rendered, including allergy extract and injections, by Birmingham Allergy & Asthma Specialists, PC to the patient, obligates me to assume financial responsibility, and I agree to pay upon request to Birmingham Allergy & Asthma Specialists, PC all charges for services incurred by the patient. If the account is referred to an attorney/collection agency for collection, I understand that I am responsible for attorney fees and collection expenses. I understand that all bills are payable upon presentation and that I, not the insurance company, am responsible for the payment of the services. This office will file and collect from insurance when insurance benefits are present. I hereby authorize Birmingham Allergy & Asthma Specialists, PC to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered.

If you have any questions regarding this notice or our health information policies, please contact:
Birmingham Allergy & Asthma Specialists, PC, Attn: Priscilla Kirkpatrick at 3125 Independence Drive, Suite 210, Homewood, AL 35209
or call (205) 943-1197 for further information.

SIGNATURE

PRINTED NAME

DATE

SIGNATURE OF PARENT/LEGAL GUARDIAN
(If applicable)

PRINTED NAME

DATE