ALLERGY AND ASTHMA CARE, P.A.

12000 ELM CREEK BLVD. #200
MAPLE GROVE, MN 55369
TEL (763) 420-1010
FAX (763) 420-3710

DATE: _____

LEGAL NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip Code

DATE OF BIRTH:	AGE:	GENDER: M ( ) F ( )	MARITAL STATUS S ( ) M ( ) SEP ( ) D ( )
HOME PHONE:	WORK PHONE:		OTHER/PAGER/CELL PHONE:
OCCUPATION:	PATIENT'S EMPLOYER:		
PRIMARY LANGUAGE: (optional)	COUNTRY OF ORIGIN: (optional)		
IS THIS VISIT WORKERS' COMPENSATION RELATED? Y ( ) N ( ) If applicable, please list Claim #			

REFERRED BY: _____CLINIC NAME: _____

PRIMARY CARE PHYSICIAN: _____CLINIC NAME: _____

PHARMACY NAME/PHONE #_____

IN CASE OF EMERGENCY, NOTIFY (list name & number):		
PRIMARY INSURANCE COMPANY:	PRIMARY INSURANCE COMPANY ADDRESS:	
CERTIFICATE OR POLICY #:	GROUP #:	
NAME OF POLICY HOLDER:	RELATIONSHIP TO PATIENT:	
POLICY HOLDER EMPLOYER:	POLICY HOLDER DOB:	
SECONDARY INSURANCE COMPANY (N/A)	SECONDARY INSURANCE COMPANY ADDRESS	
CERTIFICATE OR POLICY #:	GROUP #:	
NAME OF POLICY HOLDER:	POLICY HOLDER DOB:	RELATIONSHIP TO PATIENT:

***IF PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION:**

LIST NAME OF RESPONSIBLE PARTY FOR PAYMENT:	LIST RELATIONSHIP TO PATIENT:	
LIST ADDRESS OF RESPONSIBLE PARTY FOR PAYMENT:	LIST PHONE # OF RESPONSIBLE PARTY FOR PAYMENT:	
MOTHER'S NAME:	DOB:	SS #:
HOME ADDRESS:	HOME PHONE:	WORK PHONE:
FATHER'S NAME:	DOB:	SS #:
HOME ADDRESS:	HOME PHONE:	WORK PHONE:

*** PLEASE READ AND SIGN THE BACK OF THIS SHEET AND RETURN WITH YOUR INSURANCE CARD TO THE RECEPTIONIST**

CO-PAYMENTS: Co-payments are due at the time of service.

FINANCIAL ARRANGEMENTS: We would appreciate your payment at the time of service. However, we understand that there may be circumstances in which you will want to make payment arrangements with our business office.

REFERRALS: If your insurance requires a referral, please obtain this referral prior to receiving care at Allergy And Asthma Care, P.A. by calling your primary physician or health plan. This will ensure your eligibility for maximum coverage by your plan. Information regarding referrals may be included on your identification card.

Please present current insurance information at the time of service. Please remember that you are ultimately responsible for any balance that your insurance plan does not cover. We cannot guarantee the amounts of coverage offered by your insurance carrier, as each policy is different.

CREDIT POLICY AND PATIENT RESPONSIBILITY: It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. It is your responsibility to know your insurance coverage. In the event your account becomes past due and is referred to an outside agency, you will be responsible for the collection costs along with any reasonable attorney fees.

A **FINANCE CHARGE** of 1.5% per month, 18% per year, may be imposed on any balance over 90 days old. We would be happy to assist you and your family in any way we can. Should you encounter any difficulties, please notify us as soon as possible to avoid any misunderstanding regarding your account.

To the best of my knowledge, I have completed the patient portion of this form, and I have read and understand my financial obligation and patient responsibility.

Signature of Insured_____ **Date**_____

Responsible Party (if minor)_____ **Date**_____

PAYMENT AUTHORIZATION/RELEASE OF RECORDS

I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE COMPANY TO ALLERGY AND ASTHMA CARE, P.A.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS AS NECESSARY TO MY INSURANCE COMPANY OR ANOTHER PHYSICIAN OR ANOTHER PARTY OF MY DESIGNATION FROM ALLERGY AND ASTHMA CARE, P.A. A signature must be on file in order to release your medical records to an insurance company or physician. Per state law, this authorization automatically expires in 12 months at which point we may find it necessary to have you complete another form.

Signature of Insured _____ **Date**_____

Responsible party (if minor) _____**Date**_____

AUTHORIZATION TO SPEAK TO SPOUSE/RELATIVE/FRIEND

If I am not available to discuss my bill or medical care, I authorize the following individual :

_____ _____ _____

Name **Relationship** **Date**