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BOARD CERTIFIED ALLERGIST

RESET

**Please complete the following form for each patient. The following information is necessary for ALL patients.**
**If you need help with the form, the Receptionist will be happy to help you.**
**Please present your insurance card to the Receptionist with this completed form. Thank you!**

## Part I – Patient Information – Please Print

**Last Name:** _____ **First Name:** _____ **Middle initial:** _____

**Address:** _____ **City:** _____ **State:** _____ **ZIP:** _____

**Home Phone:** _____ **Cell Phone:** _____

**Work Phone:** _____ **E-mail:** _____

**Social Security No.:** _____ **Birth Date:** _____ **Sex:** M F **Martial Status:** S M D Sep W

**Spouse's Name:** _____ **Work Phone:** _____

**Referred by:** _____ **Primary Care Doctor:** _____

**Emergency Contact:** _____ **Phone:** _____ **Relationship:** _____

## Part II – Patient Employer/School Information

**Employer/School Name:** _____ **Phone Number:** _____

**Address:** _____ **City:** _____ **State:** _____ **ZIP:** _____

## Part III – Person Responsible for Payment/Guarantor

☐ *Check Here if Patient is Same as Responsible Party and Skip to Part IV*

**Name:** _____ **Relationship to Patient:** _____

**Address:** _____ **City:** _____ **State:** _____ **ZIP:** _____

**Home Phone:** _____ **Cell Phone:** _____

**Work Phone:** _____ **E-mail:** _____

## Part IV – Insurance Information

**Primary Insurance Company:** _____ **Address:** _____

**Policy or Identification Number:** _____ **Group Number:** _____ **Effective Date:** _____ **Policy Name:** _____

**Social Security Number:** _____ **Date of Birth:** _____ **Place of Employment:** _____

**Secondary Insurance Company:** _____ **Address:** _____

**Policy or Identification Number:** _____ **Group Number:** _____ **Effective Date:** _____ **Policy Name:** _____

## Part V – How Did You Hear of Us?

◯ **Newspaper** ◯ **Radio** ◯ **Physician** ◯ **Family/Friend** ◯ **Sign** ◯ **Internet** ◯ **Yellow Pages** ◯ **WHAG** ◯ **Patient**

_____ _____
*Signature* *Date*

**Policy continued on the back of this form**

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of my medical records, if necessary.

I understand that payments of charges incurred; co-pays, co-insurance deductibles and non-covered services are **DUE AT THE TIME OF SERVICE** unless other definite financial arrangements have been made prior to treatment.

I agree to pay all reasonable attorney fees and collection costs in the event of defaults of payment of my charges.

I understand that there will be a $5.00 service fee if there is a need to bill for unpaid balances.

I understand there will be a $25.00 service fee if co-pay/co-insurance is not paid at time of service.

I understand there will be a $20.00 service fee for returned checks.

I understand that appointments not cancelled within 2 business days of the scheduled appointment will be charged a $25.00 fee.

I acknowledge full financial responsibility at the time services are rendered for care not authorized by my HMO/POS plan.

I accept full financial responsibility if incorrect insurance information is provided that results in a denial of claims.

I understand the staff will assist in dealing with my insurance company, but it is my responsibility to know and understand my own insurance.

***Please initial to verify you have read and understand these policies.*** **_____**

We appreciate the confidence that you have expresses in selecting us as your physician. It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstanding at a later date. If you have any questions about our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

***Drs. Paul M. Mauriello and Nicholas A. Orfan***