CHART# ____________

PATIENT INFORMATION

(Please complete every line)

DOCTOR ____________

Welcome To Our Office

DATE ____________

PATIENT'S NAME (Please Print)	MARITAL STATUS S M W D Sep	DATE OF BIRTH	AGE	SEX M F	RACE	SOCIAL SECURITY NO.

STREET ADDRESS or P.O. BOX	CITY AND STATE	ZIP CODE	HOME PHONE NO.
			CELL PHONE NO.
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (Indicate if Student)		WORK NO.
EMPLOYER'S MAILING ADDRESS	CITY AND STATE		ZIP CODE
DRUG ALLERGIES, IF ANY	Email Address:		
SPOUSE OR PARENT'S NAME (Required for minors)	*SOCIAL SECURITY NO.*	*DATE OF BIRTH*	
INSURANCE (Primary)	GIVE NAME OF POLICY HOLDER	DATE OF BIRTH	SOCIAL SECURITY NO.
INSURANCE (Secondary)	GIVE NAME OF POLICY HOLDER	DATE OF BIRTH	SOCIAL SECURITY NO.

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S)? INCLUDE NAME OF FAMILY MEMBER AND PHYSICIAN

REFERRED BY OR FAMILY PHYSICIAN:	PREFERRED PHARMACY:

PLEASE READ: All Professional Services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/ Other Insurance company benefits be made either to me or on my behalf to ALLERGY, ASTHMA & SINUS CENTER, P.C. for any services furnished me by that party who accepts assignments physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare Other Insurance company claim.

I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare Other Insurance company assigned cases the physician or supplier agrees to accept the charge determination of the Medicare Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are base upon the charge determination of the Medicare Other Insurance company.

Signature ____________ **Date** ____________

PATIENT CONSENT FORM

The Department of Health and Human Services has Established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ______________________ Signature: ______________________ Date: ____________

Form 0108 *(Back)*