



PATIENT INFORMATION

Today's Date: ___ / ___ / ____ Primary Care Physician _____ Referring Physician _____

HOW YOU WERE REFERRED TO OUR OFFICE: PHYSICIAN INSURANCE NEWSPAPER AD PHONE BOOK FRIEND OTHER

First _____ Middle _____ Last _____

Preferred Name _____ Gender: Male Female Date of birth: ____ / ____ / ____

Marital status: Single Married Divorced Separated Widow(er) Other Social Security Number ____ - ____ - ____

PLEASE CIRCLE

RACE	ETHNICITY	NATIONALITY	LANGUAGE
American Indian	Hispanic	African American	Hispanic
Alaska Native	Latino	American	Irish
Black or African Amer.	Non Hispanic	Arabian	Italian
Hispanic	Other	Asian-Indian	Japanese
Multiracial	Refuse to Report	Australian	Korean
Other		Bavarian	Mexican
White		British	Polish
		Chinese	Puerto Rican
		Eastern-European	Russian
		European	Scotch-Irish
		Filipino	Scottish
		French	Spanish
		German	Refuse to Report

Address: _____ City _____ State _____ Zip _____

Phone Number () _____ home () _____ cell () _____ work

Email: _____ Email: _____

PRIMARY INSURANCE:

_____ Member ID _____ Group # _____ Copay _____

Insurance Subscriber Name: _____ Insurance Subscriber Date of Birth: _____

Relationship to subscriber: _____

SECONDARY INSURANCE:

_____ Member ID _____ Group # _____ Copay _____

Insurance Subscriber Name: _____ Insurance Subscriber Date of Birth: _____

Relationship to subscriber: _____

RESPONSIBLE PARTY INFORMATION (If other than patient):

Name: _____ Date of birth: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____

I authorize the release of medical information necessary to process claims or obtain treatment. I authorize payment be made directly to the physician/clinic for services or supplies provided. I understand I am responsible for charges not paid by my insurance. I understand I am responsible for obtaining referrals for services/supplies needed and I will be charged for those supplies/services received without a referral in place.

PATIENT / PARENT SIGNATURE or LEGAL REPRESENTATIVE DATE

TURN OVER AND COMPLETE BACK SIDE OF THIS FORM

FINANCIAL POLICY for Northern Colorado Allergy & Asthma Clinic, LLC

Please understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients.

- ◆ We must emphasize that as a health care provider our relationship is with you, not your insurance company.
- ◆ Your insurance is a contract between you, your employer, and the insurance company.
- ◆ Contact your insurance company and/or your employer's human resource department with regards to your benefit questions.

PATIENT RESPONSIBILITIES:

Insurance Card(s): We require a copy of your current insurance card upon and with every antigen order.

We require your signature and a current card with every antigen order also.

Co-payments: **Co-payments are due at time of service.**

Referrals: If your insurance requires a referral, and you do not provide one at the time of service, you are responsible for any charges incurred.

Cancellations: **For all appointments there is a 24 hour cancellation notice requirement.**

There is a \$25.00 charge for repeated late cancels or no shows.

There is a \$50.00 charge for the same on new patient appointments.

If you have health insurance with which we participate:

- We will bill your insurance claim for you.
- We expect any required copayment at time of service.
- We expect payment of deductible and coinsurance to be paid in full after we have issued you a statement to be paid within 25 days unless prior payment arrangements have been made.

If you are uninsured or we do not participate with your insurance:

- We require you to sign an uninsured form.
- Payment for total charges are due in full on the day of your appointment unless you have signed a credit agreement with our office.

General:

Payment of services is due by the person accompanying any minor child unless other arrangements have been made in advance. We will not bill two people for care. It is the responsibility of the accompanying adult to pay the amount due in full, and collect what is owed by others.

We accept payments in cash, check and credit (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS). Post-dated checks are acceptable within 2 weeks and will be deposited on the check date.

There will be a \$15.00 charge for returned checks. Accounts over 90 days are subject to collection proceedings.

I have read and accept the terms of this financial policy.

Date: _____ Signature: _____

HOW WOULD YOU LIKE FOR US TO CONTACT YOU

For non-medical issues:

Phone () _____ U.S. Mail E-MAIL(non encrypted) _____ Patient Web Portal

For medical issues:

Phone () _____ OK Not OK to leave a message

U.S. Mail Patient Web Portal

I authorize the following individuals to inquire and receive verbal information regarding my care and signed medical release. (Actual release of medical records requires a separate form).

1. _____ Relationship _____ Date of Birth _____

2. _____ Relationship _____ Date of Birth _____

3. _____ Relationship _____ Date of Birth _____