PLEASE PROVIDE INSURANCE CARD AND DRIVER'S LICENSE FOR IDENTIFICATION & INSURANCE USE

PARTNERS IN ALLERGY & ASTHMA CARE, PA
PATIENT INFORMATION
(Please Print)

PATIENT NAME_____ M/F_____

Single / Married / Div / Wid DOB_____ EMAIL:_____

ADDRESS_____ CITY/ST_____ ZIP_____

PHONE (Home)_____ (Cell)_____ (Work)_____
(PLEASE CIRCLE PREFERRED CONTACT #)

EMERGENCY CONTACT:

NAME_____RELATION TO PT_____ PHONE#_____

PRIMARY CARE/REFERRING DOCTOR:_____

PHARMACY & ADDRESS_____

PRIMARY INSURANCE:_____SUBSCRIBER:_____

SECONDARY INS. if any_____SUBSCRIBER:_____

RACE: ☐ White ☐ Black/African American ☐ Asian ☐ Not Provided
LANGUAGE: ☐ English ☐ Spanish ☐ Other _____
☐ ***I prefer my reminder calls to be in Spanish.***
ETHNICITY: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Not Provided

PRIVACY POLICY ACKNOWLEDGEMENT
With my consent, Partners in Allergy & Asthma may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations, as well as to comply with a subpoena or worker's compensation matter. I further authorize the office of Partners in Allergy & Asthma to access my medication history through their electronic prescription service. I have the right to review Partners in Allergy & Asthma's *Notice of Privacy Practices* prior to signing this consent. I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent. In addition, I authorize Partners in Allergy & Asthma to leave a message regarding appointment reminders with whomever answers my home phone or on my answering machine.

ASSIGNMENT AND RELEASE
I certify that I and/or my dependent(s) have insurance coverage with the above insurance company(ies) and assign directly to Partners in Allergy & Asthma all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature of all insurance submissions. The above named practice may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed, or one year from the date signed below. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize the office to download my medication history and Rx benefits into my account from an Rx clearinghouse.

PATIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY NAME:_____ RELATIONSHIP:_____
(If patient is a minor)

RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____