Allergy Asthma Ear Nose & Throat
2802 Leonard Drive Valparaiso, IN 46383
PH: 219-531-5855 Fax: 219-531-1617

Patient Information:

Name_____ _____DOB:____/____/____Age____Sex: M___F___

Address_____City_____State_____Zip_____

Social Security No_____Home Phone_____Cell Phone_____

Employer_____Work Phone_____Email_____

Insurance Information:

Primary Insurance_____Policy ID No_____

Address_____Group No_____Effective Date___/___/___

Policy Holder's Name_____DOB___/___/___Social Security No_____

Secondary Insurance_____Policy ID No_____

Address_____Group No_____Effective Date___/___/___

Policy Holder's Name_____DOB___/___/___Social Security No_____

Responsible Party:

Name_____DOB___/___/___Social Security No_____

Address_____Home No_____Cell No_____

Emergency Contact

Name_____Relationship to Patient_____Phone_____

By my signature below I:

(A) Authorize payment directly to Allergy Asthma Care, P.C., for the surgical and/or medical benefits, if any otherwise payable to me for the services; and
(B) Authorize to release information acquired in the course of my examination or treatment to referral physician or your insurance company.
(C) I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____Signature_____Date___/___/___

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Kenneth W. Blumenthal, DO
Sutinderpal (Paul) Judge, MD
Michael Keenan, MD
Lauren Rigg, MD
James Turk, DO
Kathy DeCorte, FNP-C
Margaret Bazarko, M.S. CCC-SLP

Allergy Asthma Ear Nose & Throat and staff are committed to providing you and your family with quality medical care at a reasonable cost. This Allergy Asthma Ear Nose & Throat Financial Policy outlines your financial responsibilities. It has been created to avoid any misunderstanding or disagreement concerning payment for professional services provided by Allergy Asthma Ear Nose & Throat and staff.

1.) Allergy Asthma Ear Nose & Throat participates in many insurance plans and managed health care programs. Our office will submit a claim on your behalf for services rendered in our office with our providers. It is your responsibility to:

   a) Provide our office with accurate, updated and complete insurance information.
   b) Bring insurance card(s) to every visit.
   c) Pay any co-pay, coinsurance, and/or deductible at each visit.
   d) Make payment in full at the time of each visit for medical care and office procedures that are not covered by your insurance plan.

2) If you have insurance for which we are not a participating provider, our office will gladly file your claim upon request. Payment for the office visit and any procedures performed is expected in full, at the time that services are rendered.

3) Patients that do not have insurance are expected to pay for all professional services provided at the time service is rendered.

4) If you are unable to pay in full for medical services provided to you and your family, it is your responsibility to call our office and make necessary arrangements with our staff in advance.

5) It is your responsibility to bring any referrals that may be required by your insurance companion the day of, or prior to your office visit. If you do not have the necessary referral at the time of service, your appointment may be cancelled or you may be held fully responsible for all charges incurred at that time.

6) If the patient is a minor (17 years old or younger), the patient's parent or legal guardian is financially responsible for any charges due at the time of service. Treatment will be denied for minors not accompanied by a parent or guardian without prior legal arrangements. The parent or legal guardian is responsible for providing complete and accurate insurance information and any necessary referrals.

7) Account balances not paid in full, may be transferred to a collection agency and/or an attorney. The collection agency or attorney will charge additional fees that will be added to your balance. If this occurs, the patient/guarantor will be responsible to pay additional costs of collection, including collection agency fees, attorney fees and interest at one and one-half percent (11/2%) per month.

8) If you have any questions about your insurance, we are happy to be of assistance. Specific coverage issues however, should be directed to your insurance company.

We at Allergy Asthma Care Ear Nose & Throat. firmly believe that a good patient-physician relationship requires understanding and good communication. Please sign below, indicating that you have read, understand, and agree to the Allergy Asthma Ear Nose & Throat Financial Policy.

_____ _____
Print Name of Patient Date

_____
Signature of Patient or Responsible Party

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The purpose of regarding  this form is to inform you about medical insurance, eligibility, cover and our policy payment for medical services.

1. All insurance policies are different and coverage of medical benefits can change without warning.
2. We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
3. You are personally responsible for knowing and understanding your own insurance policy, coverage, and benefits.
4. Not all insurance companies or third party payers pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
5. All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
6. You are financially responsible for payments of all non-covered procedures or services, including but not limited to Allergy Injections and Allergy Testing.
7. In the event of ineligibility for coverage of plan benefits, as well as non-authorized or non-covered procedures or services, you understand you are fully financially responsible for payment.
8. If you have questions about your insurance, we are happy to be of assistance. Specific coverage however, should be directed to your insurance company.

We at Allergy Asthma Ear Nose & Throat. firmly believe that a good patient-physician relationship requires understanding and good communication. Please sign below, indicating you have read, understand, and agree to this financial agreement with Allergy Asthma ear Nose & Throat

_____ _____
Print Name of Patient Date

_____ _____
Signature of Patient or Guardian Date

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I, _____, have been offered or received the Privacy Notice for Allergy Asthma Ear Nose & Throat and signed the authorization for the following:

Please list below whom we can speak with and release information to:
(Please Understand a Medical Records release will need to be signed)

Family or Friend Name:	Relationship to the Patient:	Phone Number:	Leave Messages and Speak with:	Review Your Account with:	Ok to Pick up Prescriptions, Orders, and Medical Records:

I allow messages to be left on the telephone number I provided on the patient information form.

____Yes ____No

Signature_____ Date_____

Relationship to the Patient:_____

Refusal of Above:_____

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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

_____ _____
Name Date

_____ _____
Signature Date of Birth