ASTHMA AND ALLERGY CLINIC, P.A.
GEETA KHARE, M.D.
2687 Jenks Ave.
Panama City, FL 32405

Patient Information:

Last Name: _____First: _____ M.I. ____

Date of Birth: _____ Gender: □ Male □ Female

Race: □ White □ African American □ Asian □ American Indian □ Black Hispanic
□ White Hispanic □ Native Hawaiian / Pacific Islander □ None / Refuse

Social Security Number:_____ Driver License #_____

Marital Status: □ Single □ Married □ Widow □ Divorced □ Separated

Street Address: _____

City:_____ State____ Zip_____

Email address:_____@_____

Home Phone _____ Cell Phone: _____

Employer _____ Work Phone _____Ext. _____

School_____

What is your preference for us to contact you? □ Home phone □ Cell Phone □ Email

Referring Physician: _____ Phone: _____

Pharmacy Preference: _____ Address:_____

Emergency Contact Information:

Name: _____ Phone: _____

Relationship to Patient: _____

If the patient is a minor child or under guardianship, then please fill out page 2. The signature below must match page 2 information and Driver's License.

I attest that the above information is correct and I have the legal authority to authorize medical treatment.
Patient Signature: _____ Date:_____

Please fill out this form if you are the parent of a minor or legally responsible for the patient

(The person legally responsible for minor or under guardianship is to fill out top portion of form)

Name: _____ Phone: _____

Date of Birth: _____ Gender: □ Male □ Female

Social Security Number:_____ Driver License #_____

Street Address: _____City:_____ State:_____ Zip: _____

Email address:_____@_____

Home Phone _____ Cell Phone: _____

Relationship to patient: □ Parent □ Legal Guardian □Other:_____
Does Patient Reside with: □ Mother □ Father □Both □Other:_____
Who has legal custody or guardianship of the patient? _____
Are there any custody issues or conflicts that we should be aware of? □ yes □no
If yes, please explain (on back of the form):

The purpose of this section is to allow you the parent or legal guardian, the option of naming other adults to bring your child (or person under your guardianship) to the office of Geeta Khare M.D. for medical evaluation and treatment. You will be giving permission for these adults to discuss the decisions regarding the medical care of the patient.
If there are no adults listed, then patient will only be seen when brought by the Parent or Legal Guardian listed above.

Who is allowed to bring the patient in for office visits and treatment:

Date	Name of Adult	Relationship to Patient	Phone Number	Date Canceled

I attest that the above information is correct and I have the legal authority to authorize medical treatment.

Signature: _____ Date:_____

Patient Name: _____ Date:_____

Patient Name:_____ Date of Birth:____/____/____

PAYMENT POLICIES

- **It is the policy of this office that the parent or legal guardian presenting the patient for treatment is responsible for payment of the patient portion of charges.**
- We make every effort to keep down the cost of your medical care. Our office fees are determined by the complexity of the procedure, the time involved, and the fee that is usual and customary for our area.
- Payment of the patient portion is expected at the time of service. We will send you a statement after we have received information from your insurance company and payment. The balance on your statement is due and payable in full when the statement is issued. If your account becomes past due by 60 days, and you have not made payment arrangements, your account will be turned over to a collection agency and you will be dismissed from the practice. You will be responsible for all collection expenses.
- We are aware that at times medical bills can be overwhelming. We make every effort to work with each patient on an individual basis to assist in making payment arrangements. It is your responsibility to call and set up a payment plan.
- If you have set up a payment plan, a payment will be required each/every month. Failure to adhere to the agreed payment plan will forfeit the payment arrangement and the account will be due in full. If you do not then pay your account in full or contact us with relevant information, your account will be turned over to a collection agency and you will be dismissed from the practice.
- Please note that due to legal requirements and contractual obligations, we must charge and collect for all co pays and deductibles.

NON-COVERED SERVICES

- Non Sufficient Funds returned checks will require complete payment in cash, credit card or money order for the amount of the check PLUS a $25.00 fee. Those patients who have an Non Sufficient Funds returned check will be required to pay for all future services with cash, credit card or money order.
- Copies of your medical records will cost $1.00 per page. This charge is the responsibility of the patient for copies sent to the patient or any third party. This charge MAY be waived under certain circumstances. This charge must be paid in full before copies will be made.
- If you require a Physician Statement, Special form, or Special Letter, this is NOT covered by your insurance. There is a separate fee for those services. These fees also must be paid in advance before the forms/letters will be filled out. Depending on the length and complexity of the form/letter you may be asked to make an additional appointment and it could take up to 30 days to be completed.

******DO NOT SIGN UNLESS YOU HAVE READ AND THROUGHLY UNDERSTAND THIS FORM! ******

I HAVE READ THE ABOVE FINANCIAL POLICIES AND AGREE TO COMPLY WITH THEM.

Signature: _____ Date: _____

Printed Name: _____

OFFICE POLICY REGARDING INSURANCE

- At Asthma and Allergy Clinic, P.A., we are happy to file with your insurance company. However, please understand that your insurance coverage and benefit levels are an agreement between you and your insurance company. It is your responsibility to determine your benefits and you will be responsible for the charges incurred for evaluation and treatment. In order to file with your insurance company, we require that all information provided be accurate and complete. If the information you provide to us is not complete and accurate, we may not be able to file your insurance and you will be responsible for the entire bill.
- We charge what is usual and customary for our area. We are not responsible for any insurance company's arbitrary determination of payment schedules. You may incur charges for services not covered by your plan. You will be responsible for these charges regardless of your insurance coverage.
- If you have more than one insurance, you will need to accurately determine which is the primary insurance and which is the secondary insurance. Please note that errors in filing with the appropriate primary insurance first may result in a denial of payment by your insurance carrier.
- While we can file with your primary and secondary insurances, we cannot file with more than two insurances. If you have more than two insurance policies, we will be happy to provide you with a copy of your encounter form so that you can submit a claim for reimbursement directly to additional insurance company after the first two insurance policies have paid.
- We will collect your "estimated patient portion" at the time of your office visit. This includes any Co-pays, coinsurances and deductibles. You will be responsible for any balances left over after your insurance has paid
- Please notify us of any changes in your insurance status when you check in. Most insurance companies will not pay after 90 days. You – the patient, parent or guardian—receive the same Explanation of Benefits that we do. Please DO NOT ignore these EOB's. It is your responsibility to update your insurance. If you fail to update the insurance, you will be responsible for the entire balance that the insurance company denies.
- If your insurance plan will only allow you to see physicians that are members of their network, please verify that we do participate with your particular plan.
- It is the responsibility of the patient to review his/her insurance coverage and to know if a referral is necessary, if pre-certification is required and/or if a second opinion is necessary.

PRIMARY INSURANCE Insurance Company _____

Policy Holder's Name: _____ Relation to Patient: _____

Birthdate_____ SS#_____

SECONDARY INSURANCE Insurance Company _____

Policy Holder's Name: _____ Relation to Patient: _____

Birth date _____ SS#_____

Patient Name:_____ Date of Birth:____/____/____

This section to be filled out if you have insurance.

OPTION 1

If you wish for us to file with your insurance, please initial each paragraph below and sign in the signature line.

_____ *(Initial)* **Assignment of Benefits:** I request that payment of authorized benefits from my insurance carrier(s) be made on my behalf directly to Asthma and Allergy Clinic, P.A., for services furnished to me by Geeta Khare, M.D. A copy of my original signature on file will be considered a valid authorization and may be substituted for the original signature

_____ *(Initial)* **Release of Information:** I further grant Asthma and Allergy Clinic, P.A. and Geeta Khare, M.D. permission to release the necessary medical information regarding my diagnosis and treatment to substantiate this or any related claim for benefits to my insurance carrier(s) or its intermediaries.

_____ *(Initial)* **Lifetime Authorization:** I understand that this authorization to pay and release information will be considered a lifetime authorization by me unless I revoke it. I certify that the information given regarding benefits is valid and correct.

_____ *(Initial)* **Financial Responsibility:** I understand that insurance coverage is an agreement between the carrier and me and is not a substitute for payment. I am personally responsible for deductibles, co-pays, and any unpaid balances. I will also be responsible for any collection expenses necessary to collect on my account.

Please sign that you have read and understand the policy regarding filing your insurance.

Signature: _____ Date_____

If you do not have insurance fill out this section.

OPTION 2

_____ *(Initial)* Please do not file my insurance company. I will file my own claims and pay in full at the time of service for care rendered at Asthma and Allergy Clinic P.A

_____ *(Initial)* I do not have insurance and I will pay in full the cost of services rendered here at Asthma and Allergy Clinic P.A

Please sign that you have read and understand the policy regarding filing your insurance.

Signature: _____ Date_____

LEVEL AND COORDINATION OF CARE

- It is our policy to send a copy of progress notes to the referring physician. This is to facilitate your treatment and to avoid conflicting therapies.
- This is a specialty clinic. Please see your primary physician for all general medical problems as well as for routine illnesses such as colds and other general health problems.

APPOINTMENTS, CANCELLATIONS, NO-SHOWS

- In our efforts to provide the best possible care at the lowest possible cost and to allow for other patients in need of care to be accommodated, please call our office as soon as possible before your appointment if you need to change or cancel your appointment.
- Any patient who does not show up for a scheduled appointment and has not informed the office in advance will be considered a "NO SHOW."
- The practice reserves the right to discontinue the physician-patient relationship with any patient who is a NO SHOW . If the relationship is discontinued, the patient will receive written notification of that decision.
- Families will not be allowed to make appointments for any family member after a NO SHOW has occurred.

PRESCRIPTION REFILLS

- We will make every effort to write your prescriptions with sufficient refills to last until your next appointment. However, if your prescription refills run our prior to your follow up appointment, please call us or have your pharmacy contact us to authorize additional refills.
- **Note that prescription refill requests require <u>two business days notice</u>. For your safety, do <u>not</u> let yourself run out of medications before requesting refills.**
- Prescriptions will be provided only for current or **ongoing** medications.
- **New medications, narcotics and antibiotics will not be called in. These medications require an office visit.**

AFTER HOURS CARE

- The doctor is available for urgent medical matters when the office is closed. To contact her, you must call the regular office number: 850-747-3665 and leave a message on the recorder. The phone system will then page the doctor and she will retrieve the message.
- Please clearly state your name, the patient's name, a call back number, a detailed description of the urgent medical matter
- If the above information is not given, your call may not be returned.
- If you use "Anonymous Call Rejection", you must remove this service (by dialing *87) in order for your call to be returned
- Please understand that diagnosis and treatment over the phone is difficult and limited. **If your matter is complex or if you have not been seen recently, you may be asked to go to the Emergency Room.**

OTHER MATTERS

- For the safety of our patients with respiratory illnesses, we ask that you refrain from wearing perfume to the office. If you are coughing or have a fever, we ask that you wear a mask to protect other patients and staff.

I HAVE READ THE ABOVE OFFICE POLICIES AND AGREE TO COMPLY WITH THEM.

Signature: _____ Date: _____

Printed Name: _____

Notice of Privacy Practices

Acknowledgement of Receipt

I, _____ acknowledge receipt of Asthma and Allergy Clinic, PA's Notice of Privacy which was effective April 7, 2003.

Patient Signature:_____

Patient Printed Name:_____

Date Signed:_____

For office use only:

We were unable to obtain a written Acknowledgement of Receipt for the following reason(s):

_____

_____

_____

_____

_____

_____

Printed Name:_____

Written Name:_____

Title:_____ Date:_____

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