CERTIFIED Allergy & Asthma of San Antonio

Medical Center | Lincoln Heights

PATIENT REGISTRATION FORM

Welcome to CERTIFIED Allergy & Asthma of San Antonio! We look forward to serving you.

PATIENT INFORMATION

Last Name	First	MI	Female ☐ Male ☐	Birth Date	Age	Home Phone# ( ) -
Address	Apt#	City	State	Zip		
SS# _ _	Work# ( ) -	Occupation	Marital Status		
E-Mail	Cell Phone# ( ) -	Primary Care Physician	Phone# ( ) -		
Employer Name/Address	City	State	Zip		
Emergency Contact	Relationship	Phone# ( ) -			

I consent to receiving email/text appointment reminders: ☐ Yes ☐ No

How did you hear about us? ☐ I was referred by Dr. _____ Phone: _____

☐ I have a (circle one) friend / family member seen at this clinic: _____

☐ I found you online (circle one): Google/ Bing / Yahoo! / Yelp / YP.com / Other: _____

INSURANCE

Primary Insurance-Name & Address		
Policy#	Group#	Effective Date
Policy Holder Name	DOB	SS#
Relationship to Patient		
Secondary Insurance-Name & Address		
Policy#	Group#	Effective Date
Policy Holder Name	DOB	SS#
Relationship to Patient		

The above information is true to the best of my knowledge. I authorize Certified Allergy & Asthma of San Antonio (CAASA) to render treatment to myself and/or my dependent. I authorize CAASA to use all of the above information to contact me, including email or SMS notifications for appointment reminders and practice correspondence. I understand my information will not be shared with anyone and that I can opt out of SMS notifications via written notice.
I understand my insurance benefits to be assigned directly to CAASA. I understand that I am financially responsible for any balance not covered by my insurance, regardless of coverage, to include any costs for collections. I also authorize CAASA or my insurance company to release any information required to process my claims.

Patient/Guardian signature _____ *Date of visit* _____

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NEW PATIENT QUESTIONNAIRE

Patient Name:_____ Birth date: _____

We look forward to your visit with us at CERTIFIED Allergy & Asthma of San Antonio. Please fill out all the information below to the best of your ability. Any information you can provide will give us a better understanding of your problem. If you are unsure about any section, you may leave it blank.

Do you have any chronic medical conditions? *(Example: asthma, high blood pressure, diabetes, acid reflux, etc.)*

Hospitalizations or Surgeries *(not including pregnancies)*	**Date**	**Hospitalizations or Surgeries** *(cont'd)*	**Date**

Current Medications *(Please list ALL medications you are CURRENTLY taking, including over-the-counter medicines, vitamins, and herbal supplements)*	**Reason for medication?**	**When originally prescribed?**

☐ I have a separate list of all my medications and have brought a copy.

Vaccination History

When was your last:

- *Flu shot?* _____ ☐ *unsure*
- *Pneumococcal?* _____ ☐ *unsure* *(e.g., "Pneumonia vaccine," Prevnar, Pneumovax)*
- *Tetanus/TD?* _____ [ ] ☐ *unsure*
- *Pertussis?* _____ ☐ *unsure*
- *TB test (PPD)?* _____ ☐ *unsure*
- *Hepatitis?* _____ ☐ *unsure*

Food or drug allergies

(Please describe any food or drug allergies, including the type of reaction.)

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Patient Name:_____ Birth date: _____

Family Medical History

(Please check any box that applies, and indicate which relative suffers or suffered from that condition.)

- [ ] Nasal allergies _____
- [ ] Asthma/COPD/Emphysema _____
- [ ] Eczema _____
- [ ] Diabetes _____
- [ ] Glaucoma _____
- [ ] Mental illness _____
- [ ] Autoimmune disease _____
  (e.g., lupus, Sjögren's , sarcoid, rheumatoid arthritis, etc.)
- [ ] Migraines _____
- [ ] Blood Pressure/Cholesterol _____
- [ ] Anemia _____
- [ ] Cancer _____
- [ ] Thyroid disease _____
- [ ] Heart disease/Stroke _____
- [ ] Recurrent infections _____
- [ ] Other (please describe) _____

Environmental Survey

(Please check any box that applies.)

Do you smoke tobacco, or are a former smoker? If so, please state type of tobacco (cigarettes, cigars, pipes), how often, and for how long you smoke or smoked. If you've quit, please say how long ago. (Example: Cigarettes, 1 pack a day for 26 years. Quit 5 months ago.)

_____

How much alcohol do you consume typically? (Example: 2 beers/day on weekends) _____

When did you move to the South Texas area? [ ] Lived here my whole life [ ] I moved here in _____

Do you live in a: [ ] house [ ] apartment [ ] mobile home [ ] duplex/town home Air-conditioning? [ ] Wall unit [ ] Central

How long have you lived at your current residence? _____ How old is your home? _____

Do you live close to any sources of pollution (i.e., next to highway or industrial plant)? No Yes: _____

What kind of flooring do you have in your **BEDROOM**? [ ] Wood [ ] Tile [ ] Linoleum [ ] Area rug [ ] Wall-to-wall carpet

Approximately how old is your mattress? _____ Do you have any feather pillows or comforters? [ ] Yes [ ] No

Please list any pets that you have (even goldfish!) _____ [ ] Indoors [ ] Outdoors [ ] Both

Do you have any hobbies? _____

Anything else you can tell us about your living environment (pipe leaks, etc.)? _____

_____

I certify that I have entered the information in this questionnaire to the best of my knowledge and ability.

_____ _____

Patient/Guardian signature Date of visit

Notice of Health Information Practices Acknowledgement

***Our privacy notice can be found in the waiting room**, and it describes how medical information about you may be used and disclosed, and how you can get access to this information. Please sign this form acknowledging having read and/or receiving notice of the policy, and return it to the receptionist. Review the policy carefully. Let us know if you have any questions or requests.*

By my signature below, I acknowledge that I have read and/or received the Notice of Health Information Practices of Certified Allergy & Asthma of San Antonio (CAASA). I understand that the organization reserves the right to change their notice and practice, and prior to implementation, will mail a copy of any revised notice, to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

(Printed name of patient or responsible party)

_____ ***Date:*** _____

(Signature of patient or responsible party)

CERTIFIED Allergy & Asthma of San Antonio

www.sanantonioallergist.com

FINANCIAL POLICY AGREEMENT

Welcome to CERTIFIED Allergy and Asthma of San Antonio (CAASA). We are committed to providing you with quality affordable health care. Please review our financial agreement below. Please voice any concerns prior to signing.

Insurance. Insurance coverage is verified prior to your appointment. Your insurance will tell us your anticipated benefits, but these are not guaranteed. ***Knowing your insurance benefits is your responsibility.*** If you do not have insurance, payment in full is expected at each visit. If you are insured but do not have an updated insurance card, payment in full is required until we can verify your coverage. Please contact your insurance for any coverage questions.

Co-payments and deductibles. All co-pays and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud! Please help us uphold the law by paying your co-pay at each visit.

Non-covered services. Please be aware that some - perhaps all - services you receive may not be covered or considered reimbursable by your insurer. You agree to pay for such services in full at the time of the visit.

Proof of insurance. We must obtain a valid copy of your driver's license and current proof of insurance. If you fail to provide the correct insurance information in a timely manner, you may be responsible for the balance of your claim.

Claims submission. We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may ask you to supply certain information to them. It is your responsibility to comply. The balance of your claim is your responsibility, whether or not your insurance company pays your claim. Remember: your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Referral. If your plan requires a referral from a primary care provider, we must have a current eligible referral on file. Please be aware that ***maintaining a current referral will be your responsibility.*** If you do not have a current referral for your visit, you will be responsible for payment of service, not your insurance.

Non-payment. If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. If a balance remains unpaid, we may be forced to refer your account to a collection agency. You and your immediate family may be discharged from this practice. You will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Paperwork and Medical Records. We charge a **$50.00 fee** to complete any FMLA, Disability, Extended Work Excuse or other forms requiring completion by the doctor. Processing will start after full payment and completion may take 3-5 business days. We charge a **$25.00 fee** for copies of medical records up to 40 pages, and $1.50 for each page thereafter. We fax records free of charge to another provider after we have received Release of Medical Records Form.

No-shows and Cancellations. We charge a **$75.00 fee** for no-shows and same-day cancellations/rescheduling of appointments. Patient will not be given a new appointment until fee is paid. This fee is not covered by your insurance company.

Insufficient Funds. We charge a **$35.00 fee** for any returned checks. The fee will be in addition to the original amount of the check. Additionally, further payment will be required in the form of credit card, cash, or money order only.

I have read, understand, and agree to all of the above.

_____

(Printed name of patient or responsible party)

_____ ***Date:*** _____

(Signature of patient or responsible party)

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www.sanantonioallergist.com

CREDIT / DEBIT CARD POLICY

At CERTIFIED Allergy & Asthma of San Antonio (CAASA), we strive to have open communication with our patients regarding financial matters. Effective August 1, 2018, we now ask that patients leave a credit/debit card on file as a guarantee of payment for any patient-responsible balances after your insurance has processed your claim.

WHY THIS CHANGE?

Dealing with insurance companies and collecting patient balances takes up an inordinate amount of time from our staff, which ultimately contributes to higher costs for patients. We do our best to estimate patient costs at the time of service based on information your insurance company gives us, but this is no guarantee. Collecting payment in a timely manner will not only help practice efficiency, but also keep costs low. Additionally, experience has proven that patient satisfaction increases when there are no concerns about delayed billing or unexpected payments.

WILL MY INFORMATION BE SAFE?

Your information will *not* be stored locally. It will be securely stored online using the same **bank-level encryption** as all your other sensitive health information.

WHAT THIS MEANS FOR YOU:

You will continue to receive a letter from your insurance carrier explaining coverage of your visit (Explanation of Benefits, or EOB). We typically receive insurance payment 2-6 weeks after patient receives an EOB. We will provide you one courtesy phone call to inform you of any remaining balance after payment by your insurance. Your credit card will then be automatically charged after 14 days for the remaining balance, if it is more than $5.

IS THERE ANOTHER PAYMENT OPTION?

You have the option to pay for your services in full on the date of service. We will file your claim with the insurance company. Once insurance pays your claim, we will **refund** you any amount you paid for that date of service. If there is any remaining balance after insurance has paid, we will deduct it from payment received on service date.

QUESTIONS? Just ask! Our staff will be more than happy to assist you.

Check one:

☐ I authorize CAASA to charge my credit/debit card for any remaining balance after my insurance has paid a service claim by CAASA. I understand my card will be securely kept on file.

Initials: _____

☐ I do NOT wish to leave a credit/debit card on file. I will pay my visit in full on the date of service and be reimbursed by CAASA after my after my insurance company has processed and paid the claim.

Initials: _____

Office use only:

CARD VISA__ AMEX__ MASTERCARD__ DISCOVER__ OTHER_____

CARD# _____

EXP_____ SECURITY CODE_____

BILLING/ZIP_____

_____

*CAASA will verify benefits, estimate the patient portion and file all insurance documents for either of the options above. I understand that it is **still my responsibility** to understand my coverage and that there is no guarantee of payment from any insurance company. This agreement is in effect as long as I have insurance coverage or until I notify CAASA in writing of a change in the above payment options. **I also understand that if my credit/debit card is declined and/or any balance owed by me is not paid within 14 days from the date insurance pays, I will be required to pay my visit in full for all future service and be reimbursed by CAASA after my insurance company processes the claim. I also agree that I will notify CAASA promptly if my credit card number changes or expires.***

Printed name: _____

Signature: _____ **Date:**_____