Birmingham Allergy and Asthma Specialists, PC

Today's Date: _____ / _____ / _____ **Date of Visit:** _____ / _____ / _____

Physician: (please check one) _____ **Dr. Carol Smith** _____ **Dr. Clara Chung**

Referred by: _____

PATIENT INFORMATION

CLINIC ID # (for internal use)	PATIENT NAME: First Middle Last	SEX	DATE OF BIRTH
			__ __ / __ __ / __ __ __ __

PATIENT HOME ADDRESS (include city, state, zip)	PATIENT HOME PHONE	PATIENT CELL PHONE

E-MAIL ADDRESS	PATIENT'S SOC. SEC. #	RELATIONSHIP STATUS: [ ] Single [ ] Married [ ] Divorced [ ] Widow [ ] Other _____	ETHNIC ORIGIN (optional)
	__ __ __ -__ __ - __ __ __ __		

PATIENT EMPLOYER NAME & ADDRESS	PATIENT WORK TELEPHONE	OCCUPATION

IF PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING INFORMATION

NAME OF LEGAL GUARDIAN (Mother/Father)	HOME PHONE	CELL PHONE	WORK PHONE
NAME OF LEGAL GUARDIAN (Mother/Father)	HOME PHONE	CELL PHONE	WORK PHONE

RESPONSIBLE PARTY (Person who is financially responsible for the clinic bill)

RESPONSIBLE PARTY: First Middle Last	RESP. PARTY SOC. SEC. #	RESP. PARTY DATE OF BIRTH
	__ __ __ - __ __ - __ __ __ __	__ __ / __ __ / __ __ __ __

RESPONSIBLE PARTY HOME ADDRESS (include city, state, zip)

RESPONSIBLE PARTY HOME PHONE	RESPONSIBLE PARTY CELL PHONE	RESPONSIBLE PARTY WORK PHONE

RELATIONSHIP OF RESPONSIBLE PARTY to PATIENT (check only one)

[ ] Self [ ] Stepmother [ ] Spouse [ ] Child-insured has no financial resp [ ] Child
[ ] Mother [ ] Stepfather [ ] Life Partner [ ] Ward of State [ ] Employee
[ ] Father [ ] Grandparent [ ] Significant Other [ ] Emancipated Minor Child [ ] Other Relationship _____

RESPONSIBLE PARTY EMPLOYMENT

[ ] Employed [ ] Unemployed [ ] Retired [ ] Other

RESPONSIBLE PARTY EMPLOYER NAME	EMPLOYER TELEPHONE

RESPONSIBLE PARTY EMPLOYER ADDRESS (include city, state, zip)

EMERGENCY CONTACT (Please list someone not living at same address)

EMERGENCY CONTACT NAME (1)	RELATIONSHIP TO PATIENT	ADDRESS
HOME PHONE	CELL PHONE	WORK PHONE
EMERGENCY CONTACT NAME (2)	RELATIONSHIP TO PATIENT	ADDRESS
HOME PHONE	CELL PHONE	WORK PHONE

INSURANCE INFORMATION (Please provide your current insurance card(s) and/or referral information)

PRIMARY INSURANCE COMPANY	SUBSCRIBER NAME	SUBSCRIBER EMPLOYER

ID NUMBER	GROUP NUMBER	EFFECTIVE DATE	END DATE	SUBSCRIBER DATE OF BIRTH
		__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

RELATIONSHIP OF RESPONSIBLE PARTY to PATIENT (check only one)

[ ] Self [ ] Stepmother [ ] Spouse [ ] Child-insured has no financial resp [ ] Child
[ ] Mother [ ] Stepfather [ ] Life Partner [ ] Ward of State [ ] Employee
[ ] Father [ ] Grandparent [ ] Significant Other [ ] Emancipated Minor Child [ ] Other Relationship _____

SECONDARY INSURANCE COMPANY	SUBSCRIBER NAME	SUBSCRIBER EMPLOYER

ID NUMBER	GROUP NUMBER	EFFECTIVE DATE	END DATE	SUBSCRIBER DATE OF BIRTH
		__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

IF PATIENT IS TRANSFERRING CARE TO OUR OFFICE, NAME OF PREVIOUS PROVIDER/CLINIC:

HOW DID YOU LEARN ABOUT OUR PRACTICE? *Please select all that apply*: ☐ Website ☐ Social Media ☐ Employer
☐ Clinic Brochure ☐ Insurance Company ☐ Newspaper/Publication/Ad: _____ ☐ School: _____
☐ Online Search (please circle): Google / Yahoo / Bing / Healthgrades / WebMD / Vitals / U.S. News Health / Other _____
☐ Referring MD: _____ ☐ Other: _____
☐ Friend: _____ ☐ Relative: _____

Authorization to Release Information
And to Pay Benefits to Provider

Please Read and Sign Below

A photocopy of this authorization may be used in place of the original.

I hereby authorize Birmingham Allergy & Asthma Specialists, PC to release any medical or patient information acquired in the course of my examination to the insurance carrier(s)/Center for Medicare and Medicaid Services and its agents needed to determine these benefits payable for related services. I also authorize release of my medical information related to my symptoms/treatment to other health care providers when my provider refers me to them for specialty services.

In addition, I also hereby authorize payment of authorized insurance/Medicare benefits be made directly to Birmingham Allergy & Asthma Specialists, PC for the medical/surgical benefits if any, otherwise payable to me for his/her services. I understand the clinic charges may exceed insurance company/Medicare payment, and if greater than such, I will be responsible for paying that additional allowable amount.

I agree to pay for charges which may not be covered by my insurance. I understand that the following services may not be covered:

_____

_____

As specified, I understand that, at any time, I may revoke this authorization of the release of my medical records. If I revoke this authorization, however, there may be difficulties in obtaining insurance payment for my treatment. In any event, I will assume complete responsibility for payment of all charges.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done.

I understand whether I sign as an agent or as a patient, that whatever services are rendered, including allergy extract and injections, by Birmingham Allergy & Asthma Specialists, PC to the patient, obligates me to assume financial responsibility, and I agree to pay upon request to Birmingham Allergy & Asthma Specialists, PC all charges for services incurred by the patient. If the account is referred to an attorney/collection agency for collection, I understand that I am responsible for attorney fees and collection expenses. I understand that all bills are payable upon presentation and that I, not the insurance company, am responsible for the payment of the services. This office will file and collect from insurance when insurance benefits are present. I hereby authorize Birmingham Allergy & Asthma Specialists, PC to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered.

If you have any questions regarding this notice or our health information policies, please contact:
Birmingham Allergy & Asthma Specialists, PC, Attn: Practice Manager at 3125 Independence Drive, Suite 100, Homewood, AL 35209 or call (205) 943-1197 for further information.

_____ SIGNATURE	_____ SIGNATURE OF PARENT/LEGAL GUARDIAN (If applicable)
_____ PRINTED NAME	_____ PRINTED NAME
_____ DATE	_____ DATE

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to…

* Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

Effective April 14, 2003, due to federal regulations HIPAA, we are required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationships, and phone numbers of any authorized individuals with whom we may discuss your medical or financial information.

	NAME	RELATIONSHIP	PHONE	FINANCIAL?	MEDICAL?
1.				☐	☐
2.				☐	☐
3.				☐	☐

If we cannot reach you, may we leave medical or financial information with the following communication?

Home Answering Machine:	☐YES	☐NO	☐N/A
Work Voice Mail:	☐YES	☐NO	☐N/A
Cell Phone Voice Mail:	☐YES	☐NO	☐N/A
Cell Phone Text Message:	☐YES	☐NO	☐N/A
Email:	☐YES	☐NO	☐N/A

_____ _____

Signature of Patient/Parent Date

IF YOU DO NOT WANT ANY MEDICAL OR FINANCIAL INFORMATION DISCUSSED WITH ANYONE OTHER THAN YOURSELF, PLEASE SIGN HERE.

_____ _____

Signature of Patient/Parent Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

_____

_____

_____

Birmingham Allergy & Asthma Specialists, P.C.

ACKNOWLEDGEMENT OF RECEIPT

HIPAA – NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the Birmingham Allergy & Asthma Specialists, P.C. Notice of Privacy Practices.

_____	_____	_____
Printed Name	Signature	Date

Birmingham Allergy & Asthma Specialists, P.C. USE ONLY

Date Acknowledgment Received: _____ Staff Initials: _____

- OR -

Reason Acknowledgment was not obtained:

_____

_____

_____

_____

BIRMINGHAM ALLERGY & ASTHMA SPECIALISTS, PC

Cancellation Policy & "No Show" Fee

Please understand that appointment times are limited. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We strive to offer our patients the best medical care and attention, and so we reserve the right to charge for these occurrences.

If you are no longer able to keep the appointment day and time you have scheduled, please call our office at (205) 943-1197 at your earliest convenience to reschedule. If you are trying to reach us outside of regular business hours, you may leave a message for our receptionists or send an email to receptionist@birminghamallergy.com for our office to contact you the next business day.

Cancellations must be made at least 24 hours in advance. Failure to do so without proper notice, or if you do not show up for your scheduled appointment, will result in a $50 fee that will be assessed. In other words, missed appointments (aka "No Show") and appointments cancelled with less than 24-hour notice, will result in a fee of **$50 charged to your account**. The patient will be responsible for these charges, not the insurance companies, and payment will be due prior to your next appointment.

If you are unable to come in the office for your appointment, please know that you have the option to convert your visit to a telemed. You may request this without penalty if you notify our office at least 2 hours before your scheduled appointment time.

Important Payment Notice

In the event of extenuating circumstances that prohibit you from keeping this appointment, please let us know your situation immediately and we will consider waiving the cancellation fee, if appropriate.

Please know that the $50 flat fee applies to standard appointments only. Certain procedures may result in a higher cancellation fee.

**All copays are due at the time of service.*

Patient/Guardian Acknowledgement

With respect to Birmingham Allergy & Asthma Specialists, I understand the office policy outlined above and agree to follow it to the best of my ability.

Patient/Guardian Signature: _____ *Date:* _____