Aloha Allergy and Immunology, LLC Patient Registration Form

Welcome to our office. Thank you for choosing our office. In order to serve you properly, we will need the following information. (Please Print Clearly). ALL information will be strictly CONFIDENTIAL.

Date:__________Patient's Name:____Birthdate:_____________Sex: M / F

Address:____(city, state, zipcode)______________________________

Mailing Address:____________________________________(city, state, zipcode)______________________________

Home Phone:_______________________Cell Phone:____________________ Work Phone:_______________________

May we leave message on your answer machine or voice mail? Yes / No Patient SSN#____________________________

Name of employer/occupation:____________________________________Business Phone#:______________________

Business address:____(city, state, zipcode)__________________________

Do you have medical insurance: Yes / No If no, how do you intend to pay? Check / Cash / Credit card

Visa / Master card / Discover Card Number:_______________________________________ Expire date______________

Insurance Company and Address:____

Subscriber's name________________________Subsriber's Birthdate:____________Subscribers SSN#_______________

Policy#:_____________________________ **Is there secondary insurance? Yes / No**

Name **AND** Address of insurance company:____________________________________Policy#___________________

Secondary subscriber's Social Security# **AND** Birthdate:____

Person financially responsible for this account? Self / Other ____

Address:____(city, state zipcode)_______________________________

Nearest friend / relative not residing with you:________________________Relationship to patient:__________________

Address:_____________________________________(city, state, zipcode)________________Phone #:_____________

Marital Status:______ Name of Spouse:____

Name and address of spouse's employer____Business#:______________

If patient is a child, Parent or Guardian's name:____

If patient is a child, who may authorize treatment for child?____

Relationship to child:______________________________ Phone#:_______________________

Whom should we thank for referring you?____

Do you authorize release of your medical information to anyone besides your insurance carrier? Yes / No

If so, whom?____

Patient, Parent, Guardian Signature:____(TURN PAGE)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:____**Birthdate:**_______________

Pursuant to Chapter 323-C, Hawaii Revised Statutes, I hereby authorize Aloha Allergy & Immunology, LLC to disclose my health information, including copies of medical records to: (a) any health insurance plan or company that provides insurance coverage for me or the named patient, for the purpose of payment of charges; (b) any insurance company that provides liability insurance to Aloha Allergy & Immunology, LLC., to evaluate clinical performance.

- This authorization shall cover the period of time from my first visit to my last visit.
- I understand that I can revoke this authorization at any time.
- This authorization shall end two years after the date of my last visit. **X**_____________

AGREEMENT OF FINANCIAL RESPONSIBILITY FOR COMMERCIAL INSURANCE

THIS DOES NOT APPLY TO QUEST PATIENTS

The agreement is between me (whose signature appears below) and my provider Aloha Allergy & Immunology, LLC.

Because this office deals with patients who are insured under a multitude of different plans within the same insurance company and whereas the contract of the insurance coverage is between the insurance company and the patient (the above named), physicians are not responsible to determine and inform the patient which services are covered and which are not.
X___________

Patient is responsible to find out from their insurance company their Co-Payments and how much percentage their insurance will cover for services such as (e.g. Office visits, skin testing, allergy treatment injections, etc.) It is understood by this contract that it is your responsibility to pay for any services that are not covered under by your insurance policy. If you have any other questions regarding billing that is associated with our office, please call **(808) 677-7727** **X**____________

I, as a patient of the above physician(s), agree to comply and pay for any services provided to me that are not covered by my insurance policy.

- **A late charge of 1% per month will be charged on account balance 60 days overdue.**
- **A charge of $15.00 will be made for checks returned.**
- **If a bill is not paid in FULL within 90 days, the bill will be sent to a collection agency. There will be a $20.00 charge for all accounts sent to collection. Also, the patient will be responsible for paying all legal fees and other costs incurred to collect the patient's bill.** **X**_____________

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(PRINT NAME OF PATIENT / PARENT / GUARDIAN OF MINOR PATIENT)

____ _______________

(SIGNATURE OF PATIENT / PARENT / GUARDIAN OF MINOR PATIENT   DATE