## ALLERGY ASSOCIATES OF WESTERN MICHIGAN, P.C.

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### PATIENT INFORMATION

(Please Print Clearly with ink pen)

Full Legal Name______________________________________________________________________________

Address_____________________________________________City________________________________Zip_______

Home Phone________________________ Cell Phone_________________________ Work Phone___________________

Email Address _______________________________________________________________________________

(By providing this email you are confirming this is a private address or one with which you are comfortable receiving direct information from us)

Date of Birth________________________________ Age ________ Gender: Male Female Choose not to answer

Social Security No.___________________________________________________________________________

Marital Status: Single Married Widowed Divorced Separated

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Please provide the following information on the patient: **Please circle all that apply**

Race: Asian Native Hawaiian or other Pacific Island Black or African American White/Caucasian
Hispanic I choose not to report this information

Is the patient of a Hispanic or Latino ethnicity? Yes No I choose not to report this information

What is the patient's first language? English Other ___________ I choose not to report this information

Referred By: PCP Family Member Friend Other _______________________________________________

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### PERSON RESPONSIBLE FOR BILL: **Must Complete**

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient's portion at the time of service.

Full Legal Name__________________________________________ Relationship __________________________________

Address _______________________________________________Home Phone __________________________________

Employer _______________________________________________Position ____________________________________

Business Address __________________________________________Business Phone________________________________

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### INSURANCE INFORMATION: **Must Complete**

Company Program Insured SS# Policy Number Group Number Policy Holder's Date of Birth

1.____________________________________________________________________________________________

2.____________________________________________________________________________________________

3.____________________________________________________________________________________________

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### EMERGENCY CONTACT INFORMATION

Name________________________________________________________________Relationship___________________

Phone Number________________________________________________ Cell Number____________________________

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### TO WHOM CAN WE SHARE PATIENT INFORMATION WITH

Name________________________________________________________________Relationship___________________

Name________________________________________________________________Relationship___________________

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**PLEASE COMPLETE THE BACK SIDE OF FORM**

PHARMACY

Preferred Pharmacy Name______________________________________________________________________

I authorize the Physicians and staff of Allergy Associates of Western Michigan to access my outside prescribing history and transmit prescription information for me to the pharmacy I have selected.

I understand that:

- This is necessary in order to coordinate prescriptions for me and reduce the risk of any possible drug interactions.
- Thy Physician may choose to deny treatment if this authorization is not granted, as the inability to access prescribing history or transmit prescription information will restrict treatment options and risk my health and safety.

MEDICAL RECORDS

- I hereby authorize the physicians of Allergy Associates of Western Michigan to release medical information including my diagnosis, medical history, and other material contained within those records to referring physicians, hospital, laboratories, and employers (if applicable, as deemed necessary).
- I also authorize the release of information necessary for processing my insurance claims.

FINANCIAL POLICY

I authorize payment of benefits, where applicable, directly to these physicians otherwise payable to me for these services.

I understand that if Allergy Associates of Western Michigan participates or is contacted by my insurance company they will:

- Bill the insurance company for covered services
- Accept cash, checks, credit cards for any fees due directly from the patient
- Accept assignment on payments from the insurance company, not including co-pays, co-insurance, deductions, or non-covered services from the patient.

I understand that as a patient of Allergy Associates of Western Michigan:

- I accept the responsibility that payment is ultimately my obligation, should I not stay within the parameters of my insurance plan.
- Payment is expected at the time of service for any deductibles, co-insurance, co-pays, non-covered services, 0r self-pay accounts.
- I am responsible for obtaining appropriate referrals or authorization from my insurance company or Primary Care Physician prior to the date of service. If this is not obtained, I will be responsible for payment at the time of service.
- If my account balance becomes overdue and is placed with a collection agency, I will be responsible to pay for all attorney or collection agency fees associated with my delinquent account.

Print Name__________________________________________________________________________________________

Patient or Responsible Party Signature____________________________________________________Date__________

Revised 3-5-20