Date_____ **Central Mass Allergy & Asthma Care** **Update Only if Checked _____**

/ / Male / Female

PATIENT Last Name **PATIENT First Name** **M.I.** **Date of Birth** **Social Security #**

Street Address / Apt # **PO Box** **City** **State** **Zip code**

❑ ❑ ❑ ❑ **Brief/request a call back** ❑ **Detailed**

Home Phone **Cell Phone** **Work Phone** ❑ **may we text appointment reminders?**

Please check which phone # is preferred and if note if we may leave a BRIEF or DETAILED message at your preferred phone number.

E-MAIL address_____ **for use with our Patient Portal** _____**Yes, sign me up!**
This web portal allows you to have secure communication with doctors or staff, access to your medical information and more.

Name of Patient's Employer and/ or School

Insurance 1	**Policy Holder NAME, or "self"**	**Date of Birth (Required!)**	**Social security #**	**Employer Name**
Insurance 2	Policy Holder Name	Date of Birth (Required!)	Social security#	Employer Name

PRIMARY CARE Physician **Other Treating Physician or Specialist** Names of OTHER FAMILY MEMBERS seen here

For Minors: Parent/guardian name lives with child? Best contact # Other Parent/guardian name Lives with child? Best contact #

Person responsible for payment? Relation to patient? Best Contact Phone Social Security# if not paying account today

Meaningful Use Reporting: Status -Circle one: Single Married Divorced Widowed Separated Language(s):_____

Ethnicity: ❑Hispanic or Latino ❑ Not Hispanic or Latino ❑ not reported [Information is for statistical purposes only---not part of PHI]

Race: ❑Amer. Indian/Alaska Native ❑ Asian ❑Black or African American ❑ White ❑ Hispanic ❑ Other _____ **❑ Unreported**

Preferred PHARMACY and LOCATION **My MAIL-ORDER PHARMACY**

_____ **I ALLOW CMAAC PHYSICIANS TO VIEW MY/MY CHILD'S PRESCRIPTION HISTORY ON FILE WITH MY INSURANCE PLAN TO**
Initials **CHECK FOR DRUG INTERACTIONS. * If you do NOT agree initial here: _____ I DO NOT ALLOW THIS ACTION.**

Office Policies/ Authorizations **PLEASE READ AND INITIAL TO ACKNOWLEDGE EACH ITEM**

_____ **BENEFITS PAYABLE TO PHYSICIAN: I hereby authorize payment go directly to my physician for medical services provided in this office. I also understand that I am responsible for copayments and any other portion of my bill that is not covered by my insurance company. I will update this office of any changes of insurance or other information that may affect billing in a timely way.**

_____ **REFERRALS: Obtaining a valid referral is a patient responsibility. I may be responsible for payment if my primary care has not approved my visit as required by some insurance plans.**

_____ **BILLING FEES: If my copayment is not paid at the time of service, a $5.00 billing fee will be charged to my account. One courtesy statement will be sent for other patient balances. Patient balances over 45 days outstanding will be subject to a $15.00 fee unless arrangements are made in advance with our billing office. I may receive or view a copy of this office's detailed financial policy upon request. Due to bank fee increase, there is a $40 fee for all returned checks or credit card payments. Billing fees are non-covered charges and are not paid by your insurance plan. *Please present any billing problems to staff as soon as possible.***

_____ **RELEASE OF INFORMATION – HIPAA: I have been offered or have received a copy of this office's HIPAA Privacy Practices policy. I also may view it on the CMAAC website, www.centralmassallergy.com at any time. Any personal information provided by me is considered confidential and will only be used as defined within the guidelines of that policy.**

I give permission for staff of CMAAC to speak with _____, be present at appointments, and share in the care, discuss information and medical treatment for myself / my dependant. Relationship of person(s):
[This statement must be retracted in writing.] _____

The information provided by me is true and accurate to the best of my knowledge. I have reviewed and understand the policies noted.

Signature of patient or legal guardian **Print name** **Date**