Central Mass Allergy & Asthma Care

Date_____

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

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

❑ **Home Phone** ❑ **Cell Phone** ❑ **Work Ph** ❑ **Brief/request a call back** ❑ **Brief text** ❑ **Detailed**

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

E-MAIL address_____

Insurance Name **Policy holder name or "self"** **Date of Birth (Required!)** **Employer Group** **Worker's Comp** ❑

Insurance Name **Policy holder name or "self"** **Date of Birth (Required!)** **Employer Group**

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

For Minors: Mother/Guardian name/lives with child? **Date of Birth** **Social Security #** **Father/Guardian** **Date of Birth** **Social Security #**

Employed? ❑ **Name of employer** **Student?** ❑ **Name of school / grade** **If over 18 years old, please ask for authorization form!**

Responsible Party **Relation to patient?** **Date of Birth** **Social Security # required if not paying today**

PATIENT Status -Circle one: Single Married Divorced Widowed Separated **Preferred language(s):**_____

Meaningful Use Reporting—Statistical only **Ethnicity**: ❑Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refused to offer

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

Preferred PHARMACY **Street** **Town** **My MAIL-ORDER PHARMACY**

_____ Initials **I allow CMAAC physicians to view *my* or *my* child's prescription history on file with my insurance plan to check for drug interactions. * If you do NOT agree initial here→ _____ I do not allow this action.**

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

_____ **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. You may be responsible for full payment or out of network rates if your primary care physician did not approve your 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. **Billing problems should be presented to staff as soon as possible so we may assist with resolutions within filing limits.**

_____ **RELEASE OF INFORMATION – HIPAA Privacy and Security:** 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.

For students over 18, parents or caregivers may complete to assign rights to other parties to share in the care of a dependent:
*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. [This statement must be retracted in writing.]
Relationship of person: _____ Restrictions? _____

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**

Office use only: *ID* *Verified* *Scanned* *Update only* *Revised 01/18*