

Princeton Allergy and Asthma Assoc., P.A.

Patient Information Please use BLACK PEN ONLY & PRINT Account # _____

First Name _____ MI _____ Last Name _____
Street Address _____ Zip _____ City _____ State _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
M ___ F ___ Date of Birth _____ SS # _____ Marital Status _____
Employer _____
Contact in an emergency _____ Relationship _____ Phone _____

How did you hear about us: Physician ___ Friend ___ Name of Friend _____
Insurance ___ Newspaper ___ Internet ___ Yellow Pages ___ Family ___ Other _____
Referring Physician Name _____ Phone _____
Address _____
Primary Care Physician _____ Phone _____

Responsible Party Information (for minors under the age of 18)

First Name _____ MI _____ Last Name _____
Street Address _____ Zip _____ City _____ State _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
M ___ F ___ Date of Birth _____ SS # _____ Marital Status _____
Employer _____
Relationship: Mother ___ Father ___ Employer ___ Legal Guardian ___ Other _____

Insurance Information

Primary Insurance: _____
Policy/ID # _____ Group # _____ Effective Date _____
Subscriber First Name _____ MI _____ Last Name _____
Street Address _____ Zip _____ City _____ State _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
M ___ F ___ Date of Birth _____ SS # _____ Marital Status _____
Relation of patient to subscriber: Self ___ Spouse ___ Son ___ Daughter ___ Other _____
Employer _____

Secondary Insurance: _____
Policy/ID # _____ Group # _____ Effective Date _____
Subscriber First Name _____ MI _____ Last Name _____
Street Address _____ Zip _____ City _____ State _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____
M ___ F ___ Date of Birth _____ SS # _____ Marital Status _____
Relation of patient to subscriber: Self ___ Spouse ___ Son ___ Daughter ___ Other _____

Any other insurance? _____

Authorization & Release

Please list any person(s) to whom we may release medical information _____

I authorize the release of any medical or other information necessary in the processing my claims. I also request the release of payment be made directly to Princeton Allergy & Asthma Associates, P.A.

Signature _____ **Date** _____

Would you like information on the benefits of participation in Clinical Research? Yes ___ No ___

If Yes, please read the following statement and sign below:

PAAA physicians are involved in clinical research. PAAA may provide you with information regarding clinical studies that you may want to participate in. Most of the clinical research studies are conducted by PAAA's affiliate organization, Princeton Center for Clinical Research. Any use or disclosure of your medical information for research purposes will maintain the privacy of your medical information and you will not be personally identified.

I authorize the release of my medical information to Princeton Center for Clinical Research. I understand that this authorization has no expiration and I may revoke this authorization at any time, giving written notice to the health care provider.

Signature _____ **Date** _____

5/14/2008

For office use only: Initial _____ Date _____

Payment Policy

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are insured by a plan we are not contracted with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you have regarding your coverage.
- 2. Copayments.** All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.
- 3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services at time of service or with-in **14** days of billing statement.
- 4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 5. Claim submission.** We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If they have not paid within **60** days, the balance will be billed to you. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- 6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- 7. Nonpayment.** If your account is over **30** days past due, you will receive a letter stating that you have **14** days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid past **45** days, we may charge a service fee of \$30 and refer your account to IC SYSTEM, a National Collection Agency authorized to credit report all debts to the four major National Credit Agencies and litigate in a court of law.
- 8. Additional cost of collection services.** Invoices shall be deemed to be accepted by you unless PAAA is notified in writing within **14** days of the invoice that you dispute it. In the event of non-payment, PAAA may, in addition to the invoice charges and service fee, charge debt collection and/or legal fees incurred by PAAA in relation to the recovery of outstanding amounts. Where any part of your medical account with PAAA has fallen into arrears, then the totality of that account shall become immediately due and payable.

Payment Policy subject to change without notice.

I have read and understand the payment policy and agree to abide by its guidelines.

Print Patient Name _____

Signature of patient or responsible party _____

Date _____

1/9/08

Please sign both sides. Over →

Office Policy

Patients with HMO or POS Plans:

- A valid referral must be presented at the time of your appointment; patients are responsible for payment in full if the proper paperwork is not on file.
- Our office must have a valid referral on file prior to preparing allergy serum for patients.
- It is the patient’s responsibility to keep track of authorized visits to our office.

All Patients

- Patients receiving allergy injections **must** wait 30 minutes before leaving our facility.
- All patients under 18 years of age must be accompanied by their parent or guardian.

Prescription refills

- Before calling our office for a refill, please check with your pharmacy if any refills are present. We require 48 hours notice if a prescription is needed.
- For proper medical care, patients must be seen within 6 months to obtain a refill.
- If your insurance company requests a 3 month mail in order, please allow ample time for the order to be received through the mail. The patient is responsible to mail in the prescription.

Medical Records and Forms

- Written authorization from the patient/parent or guardian must be obtained to release medical records.
- One week’s notice is required to complete your request for medical records and/or the completion of forms.
- **A \$10.00 processing fee applies to the above requests.**

No Show and Cancellation Fee

- A 24-hour cancellation notice is required for all appointments. **A fee will be implemented if required notice is not given.**

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.

A FEE OF \$25.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY OUR OFFICE OF ANY INSURANCE AND/OR DEMOGRAPHIC CHANGES.

Office Policy subject to change without notice.

I have read and understand the office policy and agree to abide by its guidelines.

Print Patient Name _____

Signature of patient or responsible party _____ **Date** _____

ACKNOWLEDGEMENT

I, _____, acknowledge that I have received a copy of Princeton Allergy & Asthma Associates P.A. Notice Regarding Privacy of Personal Health Information.

Date: _____

Patient Name _____

Patient/Guardian Signature _____

CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ (Patient Name), of _____ (Address), give to Princeton Allergy & Asthma Associates P.A. my consent to use and disclose any and all protected health information created by Princeton Allergy & Asthma Associates P.A. and/or maintained in my medical record (defined to include all medical reports, diagnosis, clinical abstracts, case histories, proposed treatment plans and prognosis, x-ray reports, insurance information and/or any other information) as necessary to carry out treatment, payment or health care operations.

I understand that a complete description of the uses and disclosures that may be made of my Health Information are set forth in Princeton Allergy & Asthma Associates Notice of Privacy Practices. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Notice of Privacy Practices is subject to change, and that if there is a change, Princeton Allergy & Asthma Associates P.A. will provide me with a revised copy.

I understand that Princeton Allergy & Asthma Associates P.A. may refuse to provide treatment to me if I do not execute this consent. I further understand that I have the right to request that Princeton Allergy & Asthma Associates P.A. restrict how my medical record is used or disclosed to carry out treatment, payment, or health care operations. However, Princeton Allergy & Asthma Associates P.A. is not required to agree to my requested restrictions. If Princeton Allergy & Asthma Associates P.A. does not agree to my requested restrictions, such restrictions will be binding.

I understand that the specific information released may contain information in reference to alcohol/drug abuse, sexually transmitted diseases, HIV/Aids infection and/or psychiatric conditions and the treatment of these disorders.

I understand that the terms of this consent are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this consent, at any time, except to the extent that Princeton Allergy & Asthma Associates P.A. has taken action in reliance thereon. I understand that any revocation must include my name, address, telephone number, date of this consent and my signature and that I should send it to:

Princeton Allergy & Asthma Associates P.A.

24 Vreeland Drive

Skillman, NJ 08558

Patient/Guardian Signature _____

Date of Consent: _____