Allergy & Asthma Center
2625 Box Canyon Drive
Las Vegas, NV 89128

PLEASE PRINT NEATLY

Patient Information

Patient Name (Last) (First) (MI)		**DOB:**	**Social Security Number:**
Home Phone #:	**Cell Phone #:**		**Work Phone #:**
Marital Status: S M D W	**Sex: M F**		**Age:**
Street Address:			**Apartment or Unit #:**
City:	**State:**		**Zip:**
Referring Physician:	**Phone #:**	**Primary Physician:**	**Phone :**
Emergency Contact:		**Phone #:**	
Email Address:	**Employer:**		**Occupation:**

Guarantor Information (if other than patient)

Guarantor Name: (Last) (First) (MI)		**SSN:**
Address (if different):		**DOB:**

Insurance Information

Primary Insurance Company Name:			**Phone #:**
Subscriber's Name:	**DOB:**		**SSN:**
Patient's Relationship To Subscriber:	**Subscriber's Employer**		
Claims Address:	**City:**	**State:**	**Zip:**
Policy ID #:	**Group #**		**Effective Date:**
Secondary Insurance Company Name:			**Phone #:**
Subscriber's Name:	**DOB:**		**SSN:**
Patient's Relationship To Subscriber:	**Subscriber's Employer**		
Claims Address:	**City:**	**State:**	**Zip:**
Policy ID #:	**Group #**		**Effective Date:**

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceeding due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor. A copy of the signature is as valid as the original.

_____ _____ _____

Patient Signature **Guarantor Signature** **Date**

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Patient/Practice Agreement and Financial Policies

Consent for Treatment

I consent to medically necessary evaluation and treatment for myself or for a minor for whom I am the legal guardian.

Financial Policies: I acknowledge my full financial responsibility for services rendered by the Allergy and Asthma Center. I understand that co-pays, co-insurance, and unmet deductibles are due at the time of service. We will bill your insurance as a courtesy, if within the United States. Current insurance information is required for billing. You (patient or responsible party) are responsible for any copayments, co-insurance, deductibles, and/or any balance due on non-covered services from your plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and possibly all, of your services provided may be non-covered by your medical insurance, in which case you will be responsible for the charges of those services.

In the event that your insurance plan changes, you are responsible for informing the Allergy and Asthma Center of this change, determining whether Allergy & Asthma Center is a participating provider for the new plan, and determining what the new co-pays, co-insurance, and deductibles are. In the event that your insurance coverage changes to a plan with which we are not participating or if you fail to provide our office with updated insurance information in a timely manner, you will be responsible for the outstanding balance that results.

There is a fee of $30.00 for appointments missed or not cancelled at least 24 hours prior. If the office is closed, patients may call the main number and leave a message with the answering service to cancel appointments.

There is a $35.00 fee for returned checks.

Minor Patients: The adult (parent, guardian) accompanying a minor is responsible for the minor's co-payment at the time of service. The parent or guardian accompanying the child(ren) to the first appointment will be considered the guarantor (responsible party) on the patient's account. The guarantor is responsible for co-payments at the time of service. If I am accompanying a minor to an appointment, I declare that I am the lawful guardian of this minor and that there are no court orders in effect at the time of service that would prohibit me from giving legal consent for the minor's medical treatment.

Release of Information: I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceeding due to lack of payment on my part, I agree to pay any and all collection fees and legal fees that may be added to my account in order to recover monies due to the doctor. I further agree that all legal proceedings will occur in Las Vegas. A copy of the signature is as valid as the original.

Thank you for choosing the Allergy & Asthma Center as your health care provider. If you have any further questions regarding your account, please call (702) 360-6100.

I have read all of the policies above and understand and agree to these policies.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Patient's name if patient is a minor

Acknowledgment of Receipt Notice of Privacy Practices

Allergy & Asthma Center

I have received a copy for review of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive my own copy of this document.

_____

Signature of Patient or Parent/Guardian or Personal Representative

_____

Signature of Patient or Parent/Guardian or Personal Representative

_____

Date

Allergy & Asthma Center
Joel Katz, MD ~ Brenda Brechler, APRN
2625 Box Canyon Drive
Las Vegas, Nevada 89128
Tel 702-360-6100 Fax 702-360-8096

Use and Disclosures of Public Health Information

To Whom May We Release OR Discuss Information Regarding Your Healthcare/Billing/PHI*?
(Family and/or Friends)

Information will not be released to anyone without your written consent.
You may change this information at any time.

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Patient Name: _____ Date of Birth: _____
(Printed Name)

Patient Signature: _____ Date: _____
(Parent or Guardian if patient is a minor)

*PHI: Protected Health Information
01/19