COASTAL
ALLERGY & ASTHMA, P.C.

Specializing in the Treatment of Adult and Pediatric Allergic Disorders

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Dear New Patient,

Welcome to our practice. We are delighted you have chosen Coastal Allergy & Asthma, PC for your allergy and/or asthma care. Your appointment is scheduled for:

Day/Date	
Time	AM / PM
Physician	Dr.

Our physicians and staff want to make your visit with us as comfortable as possible and minimize your wait time in our lobby; therefore we have enclosed our new patient information packet. On the day of your appointment, please bring the following with you:

- The attached **forms** completed
- A list of all **medications** you are currently taking
- Your **insurance** card

Feel free to call our office at **912-354-6190** or toll free at **866-273-2849** if you should have any questions or if you need to reschedule this appointment.

Directions to our offices are provided on the back of this letter. Timeliness is important to our office. If you arrive 15 minutes late for your appointment, out of consideration for other scheduled patients, your appointment may be rescheduled for another date.

We look forward to having you as our patient.

Sincerely,

The staff and physicians of Coastal Allergy & Asthma, PC

COASTAL ALLERGY & ASTHMA, P.C.
Patient Information Form

Date_____ Appt. Date_____ New Patient ☐ Former Patient ☐ Doctor _____

How did you hear about us... ☐ Physician Referral ☐ Internet ☐ Television ☐ Radio ☐ Newspaper ☐ Friend/Family ☐ Other_____

Referring Physician_____ Phone Number_____ Primary Care Physician _____

Reason for Visit/Referral_____ Date of Onset _____

Patient's Personal Information

Male _____ Female _____

Name_____ DOB _____ SSN_____ Marital Status M S W D
Last First MI

Street Address_____ City_____ State_____ ZIP_____

Mailing Address_____ City_____ State_____ ZIP _____
(If different from above)

Home Phone_____ Work Phone_____

Employer's Name_____ Address_____

Occupation_____ Phone Number_____ ext. _____

Guarantor's Personal Information

(Person responsible for bill) Male _____ Female _____

Name_____ DOB _____ SSN_____ Marital Status M S W D
Last First MI

Street Address_____ City_____ State_____ ZIP_____

Mailing Address_____ City_____ State_____ ZIP _____
(If different from above)

Home Phone_____ Work Phone_____

Employer's Name_____ Address_____

Occupation_____ Phone Number_____ ext. _____

Spouse Information

Name_____ Address (If different from patient)_____

DOB_____ SSN_____ Home Phone_____ Work Phone _____

Employer's Name_____ Address_____ Occupation _____

Insurance Information

Primary Insurance _____ Group Number_____ Policy Number _____

Claims Address_____
City State ZIP

Insured_____ Patient Relationship to Insured _____

Insured SSN_____ Insured DOB_____ Co-pay $_____

Secondary Insurance _____ Group Number_____ Policy Number _____

Claims Address_____
City State ZIP

Insured_____ Patient Relationship to Insured _____

Insured SSN_____ Insured DOB_____ Co-pay $_____

Emergency Contact (Not living in same household) Name_____

Address_____ Phone No._____ Relationship_____

Authorization to Treat and Release

In connection with my care and treatment I authorize Coastal Allergy & Asthma PC to release to, and receive from, any Doctor, Hospital, Clinic, other Healthcare Provider, or Insurance Carrier any medical records or information relating to my health, including without limitation, any information relating to illness or disease cause, treatment, diagnoses, prognoses, laboratory and/or radiology test and/or procedures, and prescriptions. The forgoing shall include records, and information relating to HIV infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), Mental Illness, and/or use of alcohol or drugs. **Your signature below fully authorizes our staff and doctors to perform examinations, diagnostic test and/or treatment, as we may consider it necessary.**

I agree to notify Coastal Allergy & Asthma PC of any changes pertaining to my address and/or insurance information.

Signature:_____ (If minor, signature of parent or guardian) Date_____

Assignment

I authorize direct payment form my Insurance Company to my provider. At any time should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred.
We will file non-contracted insurance as a courtesy; however, if we have no response from your insurance company within 60 days, the charge(s) will be transferred to your responsibility to pay.

Signature:_____ (If minor, signature of parent or guardian) Date_____

Coastal Allergy & Asthma, PC
Patient Financial Policy

Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services.

Payment Policy

- Payment is due at the time services are rendered unless other arrangements have been made by either you or your insurance company.
- We accept cash, check, Visa, Mastercard, American Express and Discover.
- Co-payments must be paid on the date service is rendered.
- Patients are responsible for their deductible or charges not reimbursed by insurance.
- If the patient is a minor (18 years or younger), the parent or guardian is responsible for payment of the account, accordance with policy outlined above.
- As a courtesy, we will automatically file your insurance claims, therefore will request a copy of your insurance card at the time of each visit.
- For services estimated to cost more that $200.00, we will accept a minimum payment of $50.00. Upon request, a short-term payment arrangement can be considered.
- You will receive monthly statements. If your account is not paid within 60 days your account will be considered past due.
- Patients having health insurance will be expected to contact their insurance carrier if there is a delay in payment. Please understand that insurance is a contract between you and your carrier, therefore, you are ultimately responsible for your bill.
- If you have difficulty paying your account, please contact our billing department.
- In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment: there are no exceptions.

Referrals

It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

Acknowledgment and Authorization

I have read, understand and agree to the above policies. I understand the charges not covered by my insurance company, as well as co-payments and deductibles are my responsibility.

I authorize my insurance benefits be paid directly to Coastal Allergy&Asthma PC.

I authorize Coastal Allergy&Asthma PC to release any medical or other information to my insurance company when requested.

Patient Name _____ Date _____

Patient's Signature _____

Parent/Guardian _____
(If patient is a minor)

Coastal Allergy & Asthma, P.C.

505 Eisenhower Dr. • Savannah, GA 31406 • Tel (912) 354-6190

HIPAA

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending the correspondence to the individual's office instead of the individual's home.

I Wish to be Contacted in the Following Manner (check all that apply):

☐ **Home/Cell Phone** _____

☐ OK to leave message with detailed information
☐ Leave message with name, practice and call-back number only

☐ **Work Telephone** _____

☐ OK to leave message with detailed information
☐ Leave message with name, practice and call-back number only

☐ **Written Communication**_____

☐ OK to mail to my home address
☐ OK to fax to this number _____

Persons Authorized to Discuss My Protected Health Information (check all that apply):

I further authorize Coastal Allergy & Asthma, PC to discuss my health information with the following persons or organizations (please give name and relationship) - for example – spouse, son, daughter, sister, brother, etc.

☐ Spouse _____
NAME

☐ Son/Daughter_____
NAME

☐ Parent _____
NAME

☐ Other _____
NAME/RELATIONSHIP

☐ Other _____
NAME/RELATIONSHIP

NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information which can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Policy containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Policy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Policy. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient's Name: _____ Patient's Signature: _____

Date:_____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Policy Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: