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_____ Cell Phone _____

Employer's Name_____ Address_____

Email_____ Occupation _____

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_____ Cell Phone _____

Employer's Name_____ Address_____

Email_____ Occupation _____

Spouse Information

Male _____ Female _____

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.

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, Co-insurance and/or deductibles 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 than $200.00, we will accept a minimum payment of $100. 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. Upon request, a short-term payment arrangement can be considered.
- In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment: there are no exceptions.

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested if you must cancel your appointment you provide more than a 24 hour notice. This will enable another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than a 24 hour notice, we are unable to offer that slot to other patients.

Appointments which are cancelled with less than 24 hours notice may be subject to a **$50.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an appointment will be considered as a **NO SHOW** and therefore, may be subject to a **$50.00** No-Show fee. Patients who No-Show more than two (2) or more times in a 12 month period, may be dismissed from the practice and will be denied any future appointments.

The Cancellation and No-Show fees are the sole responsibility of the patient or guarantor and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance, may be waived but only with management approval.

Our practice believes that good physician/patient relationship is based upon understanding and good communication. If you have any questions concerning the policy, please do not hesitate to contact our office.

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, co-insurance 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/Guardian 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:

COASTAL
ALLERGY & ASTHMA, P.C.

Follow My Health

"The Electronic Patient Portal"

This will allow you to:

- Request Prescription Refills on line
- Ask a question to our staff
- Receive SECURE messages from our staff
- Complete new patient forms and update demographic information
- Secure Bill Pay Online

In order for you to have access to online features, we will need you to provide your email address.

Please complete the bottom of this form with your information and return to our receptionist.

Thank you very much!

PLEASE PRINT

Patient Name: _____

DOB: _____

Guarantor's Name: _____
(if applicable)

Daytime Phone #: _____

Email address: _____