

ALLERGY & ASTHMA AFFILIATES
SRINAGESH PALUVOI, M.D.
Diplomate, American Board of Allergy and Immunology

PATIENT REGISTRATION (PLEASE PRINT CLEARLY)

NAME: First		Middle		Last		Date of birth		Social Security		
HOME: Address				apt#		City		State		Zip Code
Occupation:		Marital Status		SEX	Home phone			Cell phone		
Employer:		Address						Work phone		
Parent or Spouse Name:		Parent or Spouse Employer				E-Mail				
Parent or Spouse Address						Spouse or Parent Work phone				
Emergency Contact:		Relationship:			Home Phone		Work Phone			
Emergency Contact Address										
Referring Physician:			Address					Telephone		
Primary Care Physican			Address					Telephone		

BILLING AND INSURANCE INFORMATION

Primary Insurance Company Name:				ID or Policy Number		Group Number	
Insurance Company Address:				Subscriber's Social Security #		Date Effective	
Subscriber's Name			Sex	Home Phone		Relationship to Patient	
Subscriber's Address			Work Phone		Subscriber's Date of Birth		
MY INSURANCE DOES OR DOES NOT REQUIRE AN REFERRAL for allergy treatment i.e office visit, serum, allergy shots, other outpatient procedures. PLEASE CIRCLE Note:if neither is circled, we will assume NO referral is required.							
Individual Responsible for bill Full Name:					Relationship to Patient		
Home Address:					City		State

WE ONLY FILE SECONDARY INSURANCE FOR MEDICARE PATIENTS

Secondary Insurance Company Name:				ID or Policy Number		Group/ Code	
Insurance Company Address:				Subscriber's Social Security		Date of Effective	
Subscriber's Name			Sex	Home Phone		Relationship to Patient	
Subscriber's Address			Work Phone		Subscriber's Date of Birth		

PATIENT'S AUTHORIZATION

I _____, hereby authorize Allergy and Asthma Affiliates Inc., to apply for benefits on my behalf for covered services rendered. I request payment by _____ (name of Ins. Co.) be made directly to Allergy and Asthma Affiliates Inc. (or in the care of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Adminstration and Health Care Financing Administration) and/ or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I authorize the release of any medical or other information necessary to process my insurance claim(s). I understand that as a patient or the responsible party for a patient, I am ultimately responsible for payment of my bill. I also take full responsibility for obtaining a valid referral, and agree to be responsible for the cost of collection efforts including reasonable attorney's fees.

Our policy is that payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, credit card, or money order.

_____ Date
 _____ Signature of Subscriber or Beneficiary

The above information is still valid: _____ Date: _____