PATIENT INFORMATION SHEET

PLEASE PRINT AND ANSWER ALL QUESTIONS DATE:_____

PATIENT'S NAME:_____
FIRST INITIAL LAST

PATIENT'S ADDRESS:_____
STREET CITY STATE ZIP

PATIENT'S HOME PHONE:_____WORK PHONE:_____ STUDENT: Y N

PATENT'S BIRTHDATE:_____ AGE:_____ SEX_____ SOCIAL SECURITY #_____

RESPONSIBLE PARTY'S NAME:_____
CIRCLE RELATIONSHIP: SELF, SPOUSE, PARENTS, FATHER OR MOTHER

RESPONSIBLE PARTY'S SOCIAL SECURITY #_____

BILLING ADDRESS:_____
STREET CITY STATE ZIP

RESPONSIBLE PARTY'S EMPLOYER:_____WORK PHONE:_____

SPOUSE'S NAME:_____SOCIAL SECURITY #_____
MOTHER OR FATHER IF MINOR

SPOUSE'S EMPLOYER: _____WORK PHONE:_____

SPOUSE ADDRESS:_____HOME PHONE:_____
(IF DIVORCED OR DIFFERENT THEN ABOVE)

IN CASE OF AN EMERGENCY CONTACT:_____
NAME PHONE NUMBER

.....

PRIMARY INSURANCE:_____
NAME ADDRESS CITY STATE PHONE NUMBER

NAME OF INSURED:_____RELATIONSHIP TO PATIENT_____

INSURED'S DATE OF BIRTH_____COPAY AMOUNT:_____

IDENTIFICATION #_____ GROUP#_____

SECONDARY INSURANCE:_____
NAME ADDRESS CITY STATE PHONE NUMBER

NAME OF INSURED:_____RELATIONSHIP TO PATIENT:_____

INSURED'S DATE OF BIRTH:_____COPAY AMOUNT_____

IDENTIFICATION #_____GROUP#_____

.....

FAMILY PHYSICIAN:_____
NAME ADDRESS PHONE

REFERRING PHYSICIAN:_____
NAME ADDRESS PHONE

Patient Responsibility For Payment Of All Services

Our Policy

All patients are responsible for the payment in full of all services rendered in their behalf. Our practice will assist patients with the payment of all fees by helping you complete insurance forms, processing forms, and mailing statements. However, you, the patient are expected to make timely payments and to follow up with your insurance carrier, as appropriate. Every account due for 45 day or more is considered delinquent.

New patients are expected to make payment in full upon delivery of services at your first visit, if no insurance.

Medicare patients: will bill your secondary insurance but you are responsible for all balances due.

Managed care patients must

- provide the necessary authorization for treatment at the first visit
- provide proof of eligibility at each visit.
- make appropriate co-payment at each visit
- meet all deductible requirements, and
- make payment for any services they contract to receive from this practice that are not covered by their insurance carriers, health plans, or HMO's

Monthly, we will mail you an itemized statement of the services you received, payment you made, and outstanding balance. Payments made close to the monthly mailing date may appear on subsequent statements.

Your insurance policy is a contract between you and your insurance carrier. This practice cannot guarantee payment of your claims by the insurance company. If the insurance company rejects your claim, in full or in part, you remain responsible for paying for services received.

Occasionally, we find it necessary to place a delinquent account in the hands of an attorney for collection. By signing this agreement, the patient or responsible party acknowledges they understand the terms of our payment policy.

Thank you.

Signature of Patient or Responsible party Date

ALLERGY & ASTHMA SPECIALISTS OF KANSAS CITY

6000 N. Oak Trafficway Suite 102 Gladstone, Missouri 64118-5176 (816)453-7771

Charles J. Siegel, M.D.
Board Certified Allergy & Immunology

Louis H. Stekoll, M.D.
Board Certified Allergy & Immunology

POLICY
Patient Consent to Leave
Detailed Message/ Information

Dear Patient:

Allergy & Asthma Specialists of Kansas City has adopted a policy that requires our staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent on file, the staff may only leave their name and phone number on a answering machine asking you to call them back.

By completing the consent form below, the staff may call and leave their name, doctor's name and additional information on an answering machine or with a specific individual.

I give consent to my doctor and/or staff of Allergy & Asthma Specialists of Kansas City to leave a message regarding treatment, lab results, or other information as necessary.

1.)_____ on answering machine at home_____ Home #_____

2.)_____ on voice mail at work _____ Work #_____

3.)_____ With_____ Relationship_____

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

Consent will be valid as long as patient is an active patient unless instructed otherwise.
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****

I do not consent to messages being left. Please contact me directly.

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

Messages will not be left unless otherwise instructed by patient or legal guardian.

NOTES:

Telephone Consumer Protection Act Consent-Medical

You agree, in order for us to service our account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collections agency may also contact you by sending text messages or emails, using any e-mail address you may provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors , and its debt collection agents may contact me/us as described above.

_____ _____

Patient Name Date

_____

Patient/Guardian Signature

ALLERGY & ASTHMA SPECIALISTS OF KANSAS CITY

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

(Please Check One)

☐ I,_____, have received a copy of Allergy & Asthma Specialists of
Patient

Kansas City Notice of Privacy Practices.

☐ I,_____, refuse to accept a copy of Allergy & Asthma Specialists of
Patient

Kansas City Notice of Privacy Practices.

_____ _____

Signature of Patient Date