

PATIENT INFORMATION FORM

Date _____

PLEASE COMPLETE ALL INFORMATION FULLY

Patient Name (Last Name, First, Middle Initial)		Sex	Date of Birth		Age
Address		City		State	Zip
Occupation		Employer		Social Security Number	
Spouse's Name		Employer		Social Security Number	
				Work Phone	

<input type="checkbox"/> BCBS <input type="checkbox"/> MEDICARE (MUST complete reverse) <input type="checkbox"/> MEDICAID/FIRSTGUARD <input type="checkbox"/> OTHER INSURER _____ (Name)			
RELATIONSHIP TO POLICY HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			
POLICY HOLDER'S NAME	POLICY HOLDER'S DATE OF BIRTH	ID#	GROUP#
<input type="checkbox"/> NO INSURANCE PLEASE DESCRIBE METHOD OF PAYMENT			

**CHECK HERE IF YOU HAVE BEEN SCREENED FOR
ASTHMA BY TOPEKA ALLERGY AND ASTHMA CLINIC**

IF PATIENT IS A CHILD OR DEPENDENT PLEASE COMPLETE THIS SECTION

DOES HE/SHE:
 Live with both parents
 Live with mother
 Live with father
 Other _____

Father's Name (Last, First, Initial)		Social Security Number		Mother's Name (Last, First, Initial)		Social Security Number			
Address			Date of Birth		Address			Date of Birth	
City		State		Zip		City		State	
								Zip	
Occupation		Home Phone		Occupation		Home Phone			
Employer		Work Phone		Employer		Work Phone			

PATIENT CONSENT AGREEMENT- Provider may condition treatment if not signed

I HAVE READ AND UNDERSTAND THE TERMS OUTLINED IN THE CLINIC PROCEDURES AND POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE. I REQUEST PAYMENT OF MEDICAL BENEFITS TO TOPEKA ALLERGY AND ASTHMA CLINIC FOR SERVICES FURNISHED TO ME. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY INFORMATION CONCERNING HEALTH CARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED TO ME FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS OF BENEFIT. A COMPLETE DESCRIPTION OF USES FOR THIS AUTHORIZATION IS AVAILABLE IN OUR PRACTICE'S PRIVACY NOTICE, WHICH IS AVAILABLE TO THE PATIENT/RESPONSIBLE PARTY UPON REQUEST.

SIGNATURE _____ **DATE** _____

Nearest friend or relative not living with you		Relationship		Phone	
<input type="checkbox"/> SELF- REFERRED (If so, how did you decide to choose our office?)			<input type="checkbox"/> PHYSICIAN REFERRED (please list first and last name)		
Family Doctor		City		Pharmacy Preference	
				City	
				Phone	

MEDICARE REQUIRES COMPLETION OF THE FOLLOWING:

MEDICARE LIFETIME SIGNATURE ON FILE

I request payment of authorized Medicare benefits to me or on my behalf to Topeka Allergy and Asthma Clinic for any service furnished to me by the physician(s). I authorize any holder of medical information to release to the Health Care financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Patient signature	Date
-------------------	------

MEDGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Topeka Allergy and Asthma Clinic for any services furnished me by the physician. I authorize any holder of medical information amount me to release to _____ (name of secondary insurance) any information about me to determine these benefits or the benefits payable for related services.

Patient signature	Date
-------------------	------

OTHER INSURANCE

Insurance or Plan Name
Policy or Group Number
Insured's Name
Insured's Date of Birth
If Insured is Employed, Please List Employer

MEDICARE SECONDARY PAYER QUESTIONNAIRE (COMPLETE FOR ALL MEDICARE PATIENTS)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Is the patient a Veteran? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Did the VA refer you here for treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Does the patient have a VA "fee basis ID card"? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a Federal Black Lung card? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is this medical condition due to an accident of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes was it: Work related <input type="checkbox"/> | | |
| Auto <input type="checkbox"/> | | |
| Injured in own home <input type="checkbox"/> | | |
| Other <input type="checkbox"/> | | |
| 4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? | <input type="checkbox"/> | <input type="checkbox"/> |

IS THE PATIENT ENTITLED TO MEDICARE BASED ON:

- 1 Age (65 & over)
- 1 Disability
- 1 ESRD (End-Stage Renal Disease)

CLINIC POLICIES AND PROCEDURES

WHO ARE WE?

Topeka Allergy and Asthma Clinic was founded in 1940 and is one of the oldest medical specialty practices in Kansas. James H. Ransom, M.D., Karl K. Kavel, M.D. and Roxana Voica, M.D. are all certified by the American Board of Allergy and Immunology. Dr. Kavel is also certified by the American Board of Pediatrics. We also have a CLIA certified laboratory.

We have satellite offices in Manhattan, Junction City and Salina. Our doctors generally see patients at these sites once a month. Patients may schedule appointments to be seen in these clinics through our Topeka office at **(785) 273-9999 or toll free at (800) 657-7217**. Additional information regarding our clinic can be found at our web site: www.taac.yourmd.com.

Because we believe in the importance of regular health care, your allergist will want to see you once a year to monitor your progress if you are on immunotherapy or prescription medications. If you are an asthmatic patient, you may need to be seen more frequently to make sure your disease is under good control. While your allergist may provide specialized care for some asthmatic patients, we do not intend to replace your family doctor.

FINANCIAL POLICIES

In establishing our financial policy, we have tried to keep in mind our goal of providing the finest medical care available. We pledge to be fair and work with you regarding your individual situation. You, on the other hand, must recognize your financial obligation to us for providing you with the medical diagnoses and care you deserve.

Fees vary with the nature of your problem and are based on the time required by the doctor and staff as well as the complexity of your individual problem. ***Please remember payment in full is due within 90 days from the date of service. Please be prepared to pay any copayments or coinsurance amounts at the time of service.***

You are responsible for obtaining information about your insurance benefits and policies as well as maintaining prior authorization (referrals). We encourage you to contact your insurance company prior to your appointment so that you may receive your maximum benefits. When doing so, please specify "allergy testing" when speaking to your insurance representative. Our office is not responsible for negotiating settlements or disputed claims with your insurance company. Please remember that your policy contract is between you and your insurance company. You are ultimately responsible for payment of your bill.

<p>PLEASE SEE REVERSE SIDE FOR IMPORTANT BILLING AND INSURANCE INFORMATION</p>

BILLING AND INSURANCE

. We contract with various HMO's and PPO's. To maximize your benefits, please contact your insurance company or our business office at **(785) 273-9898** to determine if we are contracting with your particular group.

PAYMENT ARRANGEMENTS

Payment in full is due within 90 days from the date of service. If you cannot pay your balance due on time, please contact our business office at **(785) 273-9898** to set up payment arrangements. Arrangements are subject to approval and must be established prior to the end of the 90 days.

Overdue accounts or consistently late payment may result in your being required to pay for all future clinic services on the day they are rendered. If your bill remains unpaid after 90 days with no satisfactory arrangement, the account may be assigned to a professional collection agency and could result in termination of your care.

THANK YOU

It is a privilege for us to provide your allergy and asthma care and we want our staff to be aware of your needs. If you have any ideas or comments that would help us to provide you with better service, please pass them along to us! Thank you for choosing our clinic.

Office Hours (Topeka)

9:00- 5:00 Monday, Tuesday & Friday

9:00 - 6:00 Wednesday

9:00 - 12:00 Thursday (not open for appointments)

CLOSED MAJOR HOLIDAYS