OCALA
1740 SE 18th Street, Suite 1002
Ocala, FL 34471

THE VILLAGES - BROWNWOOD
2793 Brownwood Blvd
The Villages, FL 32163

THE VILLAGES - LA GRANDE (SPANISH SPRINGS)
309 La Grande Blvd
The Villages, FL 32159

PATIENT INFORMATION REGISTRATION FORM

Your information is protected by HIPAA. Please see our Notice of Privacy Practices

PERSONAL INFORMATION

Patient's Full Name: ________________________ DOB: ____/___/____ Age: _____ Sex: ☐ Male ☐ Female

Address: ________________________ City: __________________ State: ____________ Zip Code: __________

Home Phone: ________________________ Cell Phone: ________________________ Email: ________________________

Social Security Number: _____ - ____ - _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Ethnicity: ☐ Caucasian ☐ African American ☐ Indian ☐ Hispanic ☐ Other

Patient's Employer: ________________________ Work Phone: ________________________

Address: ________________________ City: ____________ State: ________ Zip Code: ____________

Occupation: ________________________ If student: ☐ Full-time ☐ Part-time

Spouse (or parent): ________________________ Cell Phone: ________________________

Address (if different from patient): ________________________ City: ________________ Zip Code: ____________

Spouse's (or parent's) Employer: ________________________ Work Phone: ________________________

In case of emergency, contact: ________________________ Relationship: ______________ Phone: ________________

Family Physician: ________________________ Phone: ________________

Referring Physician: ________________________ Phone: ________________

Pharmacy: ________________________ Phone: ________________

INSURANCE INFORMATION:

We ask all patients to present their insurance cards to the receptionist.
All co-payments and deductibles are to be paid at time of service.

Name of Primary Insurance Carrier:

____

ID#: ________________________

Group #: ________________________

Insured Party's Name: ________________________

Insured's DOB: ____/____/_____

Insured's Social Security: ____ - ____ - _______

Patient's Relationship to Insured ____________

Name of Secondary Insurance Carrier:

____

ID#: ________________________

Group #: ________________________

Insured Party's Name: ________________________

Insured's DOB: ________________

Insured's Social Security: ____ - ____ - _______

Patient's Relationship to Insured ____________

I hereby authorize my insurer (s) to pay benefits directly to Allergy & Asthma Care of Florida

Signature of Patient/Parent/Guardian: ________________________ Date: ________________

Medication Record

Patient name ____

Date of Birth ____________

Please list all medications you are taking (including over the counter medications, nasal sprays and inhalers)

Medication	Dose given

Please list any medication to which you are allergic and the type of reaction

Have you had any of the following vaccines:

Influenza (Flu) ☐ yes/no ☐ Date __________

Pneumonia ☐ yes/no ☐ Date__________

Shingles ☐ yes/no ☐ Date__________

COVID 19 ☐ yes/no ☐ Date _________

Allergy & Asthma
Care of Florida

AllerVie
HEALTH

Disclosure of Protected Health Information

I understand that Allergy and Asthma Care of Florida has the right to disclose my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Allergy and Asthma Care of Florida.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Allergy and Asthma Care of Florida is not required to agree to the restrictions that I may request. However, if Allergy and Asthma Care of Florida agrees to a restriction that I request, the restriction is binding on Allergy and Asthma Care of Florida. I have the right to revoke this consent, in writing, at any time. My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that I have the right to authorize or restrict the release of my HIV/AIDS status, drug/alcohol abuse notes and qualified mental health notes to referring and family physicians and to my insurance company, if applicable.

I understand I have a right to review Allergy and Asthma Care of Florida's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Allergy and Asthma Care of Florida. The Notice of Privacy Practices is provided at the front desk or in the waiting room. This Notice of Privacy Practices also describes my rights and Allergy and Asthma Care of Florida's duties with respect to my protected health information.

Allergy and Asthma Care of Florida reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain access to the revised notice by contacting Allergy and Asthma Care of Florida's Privacy Officer.

Patient's Name ________________________________

Patient's Date-of-Birth ________________________________

Signature of Patient or Personal Representative________________________________

Printed name ________________________________

Date ________________________________

Description of Personal Representative's Authority

____

PATIENT RECORD OF DISCLOSURES

HIPAA Privacy Regulations gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead.

Allergy and Asthma Care of Florida will contact patients using phone numbers and emails provided by the patients. Please check off any contact methods you **do not** want us to use for you.

□ I do not wish to be contacted on my cell phone
□ I do not wish to be contacted on my land line
□ I do not wish to be contacted by email
□ I do not wish to receive secure text messages on my cell phone
□ I do not want detailed information left on my voice mail or answering machine

Personal Contacts- O.K. to release Protected Health Information to the following person(s):

Name:____________________________ Relationship:_________________________
Name:____________________________ Relationship:_________________________

I understand that it is my responsibility to change this information should my circumstances change. I will notify Allergy and Asthma Care of Florida of any changes.

Patient's Name (please print) ____

____ ____________________
Patient Signature/Personal Representative Date

____ ____________________
Printed Name Patient's Date of Birth

Allergy & Asthma Care of Florida, Inc.

Financial Policy and Insurance Billing Information

We are dedicated to providing you with the best possible care and service. Your understanding of our financial policies is an essential element of your care and treatment. Our policy is that unless other arrangements have been made in advance, **full payment is due at the time of service**. This enables us to avoid the cost of sending monthly statements, thus allowing us to keep our fees down. For your convenience we accept Debit cards and most major credit cards.

Insurance Plans:

We have made arrangements to accept a wide variety of medical plans. We will be filing claims according to our contract with each company. We will bill those plans with which we have an agreement and will collect any required co-payment, coinsurance and deductible from you at the time of service. In the event your health plan determines a service to be "not covered", you may be responsible for the complete charge. In the event that we bill you, your payment will be due upon the receipt of that statement. For your information, we recommend that you contact your insurance carrier to determine benefits for your care in our office. We may contact you once we verify your coverage to help you understand your responsibility.

Medicare:

Medicare doesn't always cover all procedures and testing that we perform in our office. If we need to perform a test that Medicare may not cover, a staff member will have you sign an Advanced Beneficiary Notice explaining this prior to the testing. If Medicare does not cover the test, you will be responsible for the charge.

Authorizations/Referrals:

Please understand that it is your responsibility to make sure each visit that your authorizations/referrals are current so that each visit is covered under your plan. Failure to do so could make the visit 100% your responsibility.

Collections:

Delinquent accounts may be turned over to our collections agency. If this occurs, the account balance, which may also include a collections fee, must be **paid in full** prior to another appointment being scheduled. Dismissal from the practice may also occur.

Missed Appointment Fees/Insufficient Funds:

Please be courteous and contact us within 24 hours to reschedule or cancel your appointment. We reserve the right to charge you $25-50 for missing your appointment. If you have a returned check, there will be a fee of $10.00. Fees of this nature must be paid in full prior to more services being rendered.

Minor Patients:

Minor patients (under the age of 18) must be accompanied by a legal guardian in order to receive care. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment at time of service. Both parents/legal guardian(s) are responsible for payment of services rendered to the patient.

I have read and understand the above financial policy of Allergy & Asthma Care of Florida. I also agree to the terms presented. By signing this form, I am also authorizing my insurer (s) to pay benefits directly to Allergy & Asthma Care of Florida.

________________________________ ________________________________

Printed Name of Patient/Guardian | Patient's Date-of-Birth

________________________________ ________________________________

Signature of Patient/Guardian | Date