ALLERGY & ASTHMA CARE, INC.

New patients: complete all sections. Established patients, check all that apply: ☐ Insurance change ☐ Other change
Please print legibly and present this completed form to the receptionist with your insurance card(s).

PATIENT NAME (First) ______________ (MI) ____ (Last) ______________
SSN ___ - __ - ____ DOB __ - __ - ____ Sex ☐ M ☐ F
Street Address ______________
City ______________ State ______ Zip ______
Landline Ph (___) ___ - ____ Cell Ph (___) ___ - ____
Email ______________ @ ______________
Marital Status ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Primary Dr ______________ Referring Dr ______________
Pharmacy ______________ Pharm Ph (___) ___ - ____

HEALTH INSURANCE? ☐ No ☐ Yes (If "Yes," all information requested below is required to file your claims.)

PRIMARY INS ______________ Eff Date __ - __ - ____
Claims Address ______________
Ins ID# ______________ Group# ______________
Patient Rel to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) ______
Policy Holder Name (First) ______________ (MI) ____ (Last) ______________
Policy Holder DOB __ - __ - ____ Policy Holder Sex ☐ M ☐ F

SECONDARY INS ______________ Eff Date __ - __ - ____
Claims Address ______________
Ins ID# ______________ Group# ______________
Patient Rel to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) ______
Policy Holder Name (First) ______________ (MI) ____ (Last) ______________
Policy Holder DOB __ - __ - ____ Policy Holder Sex ☐ M ☐ F

Additional medical coverage? ☐ No ☐ Yes (If "Yes," please request another form.)

FINANCIAL RESPONSIBILITY
☐ **Self** (If "Self," skip to bottom to date and sign. Patient must be 18 years of age or older to select this option.)
☐ **Other** (Required if patient is under 18 years of age. Please complete the section below.)

NAME (First) ______________ (MI) ____ (Last) ______________
DOB __ - __ - ____ SSN ___ - __ - ____ Sex ☐ M ☐ F
Street Address ______________
City ______________ State ______ Zip ______
Landline Ph (___) ___ - ____ Cell Ph (___) ___ - ____
Email ______________ @ ______________ Rel to Patient ______________

I hereby authorize treatment, and also the release of any and all HIPAA-protected information required to process this patient's medical claims. I authorize Allergy & Asthma Care, Inc. to apply for benefits to be paid on this patient's behalf for services rendered by their doctors and staff, and assign all benefits directly to Allergy & Asthma Care, Inc. I understand that healthcare insurance is a contract between the insured and the insurance company, and not the insurance company and the doctor, and agree that I am ultimately responsible for all fees incurred during the care of the patient noted above. I certify that the information I have reported above is correct, current, and true, and agree that a copy of this authorization may be used in place of the original.

Date __ - __ - ____ **Signature** ______________

(For patients under 18 years of age, parent/guardian must sign.)

ALLERGY & ASTHMA CARE, INC.

PATIENT COMMUNICATION PREFERENCES AND PERMISSIONS

Please print legibly and return completed form to the receptionist.

Patient Name (First) ________________ (MI) ____ (Last) ____________________

Patient DOB __ __ - __ __ - __ __ __ __

Because we value your right to privacy, we need to know your preferences regarding our communications with you. We routinely call our patients for a variety of reasons, including the following:

- To schedule and confirm appointments
- To discuss lab or test results
- To respond to patient questions and concerns
- To address billing, insurance, or other account issues

If we need to speak with you about the patient named above, what number(s) should we call?

Landline Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Cell Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Can we leave a detailed message on an answering machine or as voice mail? (Please check one.)

☐ Yes.

☐ No. Leave only a name and number and someone will return your call.

Please list below any individuals who may contact us or be contacted by us about this patient. Check the "Emergency Only" box for anyone we can't share protected information with unless it's a medical emergency.

1. Relationship to Patient ______________________ ☐ Emergency Only
   Name (First) ________________ (MI) ____ (Last) ____________________
   Landline Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Cell Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
2. Relationship to Patient ______________________ ☐ Emergency Only
   Name (First) ________________ (MI) ____ (Last) ____________________
   Landline Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Cell Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
3. Relationship to Patient ______________________ ☐ Emergency Only
   Name (First) ________________ (MI) ____ (Last) ____________________
   Landline Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Cell Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
4. Relationship to Patient ______________________ ☐ Emergency Only
   Name (First) ________________ (MI) ____ (Last) ____________________
   Landline Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Cell Ph (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Thank you for letting us know how to keep you informed about issues relevant to your healthcare. If any of the information above changes, you are responsible for notifying us of that change. Please request a new form or provide other written and signed notification at that time.

Date __ __ - __ __ - __ __ __ __ **Signature** ______________________________

(For patients under 18 years of age, parent/guardian must sign.)

John Seyerle MD ♦ Ashish Mathur MD ♦ Jeffrey Raub MD
Board Certified, Allergy & Immunology

Specializing in Adult and Pediatric Allergies and Asthma

Main Office / Tri County (Springdale)
422 Ray Norrish Dr #2
Cincinnati OH 45246
513.671.6707

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help ensure that Personal Healthcare Information (PHI) is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers in obtaining patient consent for the uses and disclosures of health care information when carrying out treatment, payment, or other health care operations.

As our patient, you should know that we respect the privacy of your personal medical records and will do all we can to secure that privacy. We strive to take every reasonable precaution to protect it at all times. When appropriate or necessary, we disclose the minimum of information required for the purposes of treatment, payment or other health care operations, and only to those we believe are in need of that information so they can provide the service and care that is in your best interest.

We may also have indirect treatment relationships with you (for example, through laboratories that only interact with physicians and not with patients), and may have to disclose Personal Healthcare Information for the purposes of treatment, payment or other health care operations in those situations. These entities are usually not required to obtain patient consent.

We fully support your access to your personal medical records, which can be provided to you after receipt of a written and signed release request. You also have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), a copy of which can be provided to you by our staff.

You may refuse to consent to the use and disclosure of all or part of your Personal Healthcare Information, but this must be done in writing. If you choose to give unrestricted consent today by signing this document, at any future time you may still revoke consent to, or request restrictions on, the use and disclosure of all or part of your Personal Health Information by notifying us in writing of the change. You cannot, however, revoke actions that have already been taken which relied on this or a previously signed consent. Please also note that, under this law, we have the right to refuse to treat you should you refuse disclosure of your Personal Health Information.

Please sign and date below if you consent to the use and disclosure of your Personal Healthcare Information as outlined above. Thank you.

Date __ __ / __ __ / __ __ __ __ **Signature** ______________________________

(For patients under 18 years of age, parent/guardian must sign.)

ALLERGY & ASTHMA CARE, INC.

NOTICE OF FINANCIAL RESPONSIBILITY

If you have health insurance and provided our staff with insurance information prior to your appointment, we will attempt to verify your eligibility, copay, and deductible status before you arrive at our office.

Based on the information obtained from your insurer, **you will be asked to pay one or more of the following on the day of your visit:**

- **Any applicable specialty care copay(s).**
- **Any applicable coinsurance percentage for all non-copay services** if your deductible has been met.
- **A 20% down payment, where applicable, for all non-copay services** if your deductible has not been met.
- **The total amount due for services already deemed "non-covered"** by your insurance.

Please note that any payment amounts requested and/or collected at the time of service are estimates only and based on the information provided to us at the time your eligibility is verified. Verification of eligibility does not guarantee insurance coverage or reimbursement for specific services. **Your total payment responsibility will not be determined until your insurer has processed your claim in accordance with the benefits available for the date of your visit.**

If you still have a balance due after your insurance has paid their portion, you will receive a monthly bill until the balance is paid in full. If you overpaid at the time of service, any credit on your account will be applied to other outstanding charges where applicable or refunded to you.

If you do not have health insurance, you will be responsible for all charges incurred during your visit. If you cannot pay in full at the time of service, please speak to our staff to make the necessary payment arrangements prior to your appointment.

Please complete and sign the following:

Patient Name (First) ____________________ (MI) _____ (Last) ________________________________

Date of Birth __ __ - __ __ - __ __ __ __

I understand that all services provided by the doctors and staff of Allergy & Asthma Care, Inc. will be charged to my account and billed to my insurer(s) and/or to me where applicable.

I understand that it is my responsibility to know and understand my health insurance benefits, and also my right to refuse or postpone any recommended or offered services for any reason. This includes questions or concerns about my insurance coverage for those services, their ultimate cost to me, and/or my ability and willingness to pay that cost.

I understand that by receiving services without explicitly exercising that right I am accepting financial responsibility for all balances due to Allergy & Asthma Care, Inc. and will be billed accordingly.

Date __ __ - __ __ - __ __ __ __ **Signature** ________________________________

(For patients under 18 years of age, parent/guardian must sign.)