ALLERGY AND ASTHMA RELIEF EXPERTS

PATIENT INFORMATION

Account #_____

(PLEASE PRINT) Today's Date: _____

Patient's Name: _____ Age: _____ Sex: _____ DOB: _____
(LAST) (FIRST)

Marital Status: Please circle one: Single Married Divorced Other

*If patient is a minor child please list: Mother's name _____ Father's name _____

Home Address: _____ City: _____ State _____ ZIP: _____

Telephone: ( ) _____ Cell phone: ( ) _____ E-Mail _____ _____

NOTICE: THE FOLLOWING QUESTIONS ARE INCLUDED TO COMPLY WITH THE NEW FEDERAL GUIDELINES; WE ARE REQUIRED TO ASK ALL PATIENTS FOR THE FOLLOWING INFORMATION:

Ethnicity: _____ Race: _____ Preferred Language: _____

Do you have Medical Insurance? □ yes □ no If yes, please list all information below.

Name of Insured: _____

Name of Insurance Co.: _____ Do you have a deductible? Yes ___ No ___

Group # _____ Subscriber ID # _____

Name of Preferred Pharmacy: _____ Pharmacy Phone: ( ) _____
Address of Preferred Pharmacy: _____

Insured Employed by: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?
Referred by Doctor: _____ Telephone: ( ) _____
Address: _____ City: _____ ZIP: _____

Referred by Friend: _____

Referred by Ins. Co_____ Internet: _____ Phone book: _____ Other: _____

Who to contact in case of emergency: _____

Relationship: _____ Telephone: ( ) _____

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR MEDICAL SERVICES RENDERED. I AUTHORIZED THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE BENEFITS.

PLEASE BE AWARE THAT IF YOU HAVE A DEDUCTIBLE YOU WILL BE BILLED AFTER THE INSURANCE IS PROCESSED. PLEASE FEEL FREE TO DISCUSS ANY QUESTIONS REGARDING YOUR DEDUCTIBLE WITH OUR OFFICE MANAGER PRIOR TO YOUR VISIT.

24 hour notice is required to cancel all scheduled appointments.
This office reserves the right to charge a cancellation fee of $25.00 if this requirement not met.

I understand and agree to the above statements. Patient's Signature: _____

ALLERGY and ASTHMA RELIEF EXPERTS

A Specialty Medical Practice
providing the highest quality care of asthma, allergies, and immune deficiencies
to adult and pediatric patients throughout the valley

Jacob Offenberger, MD, FAAAAI, FACAAI
Cornelia Licona, MD – Cecilia Euredjian, PA-C

10515 BALBOA BLVD #390, GRANADA HILLS, CA 91344
PH: 818 366-8112 FX: 818 3666002

27141 HIDAWAY AVE. #204, CANYON COUNTRY, CA 91351
PH: 661-298-1491 FX: 661-298-1492

PATIENT FINANCIAL AGREEMENT

Allergy and Asthma Relief Experts has adopted the following financial policy to communicate with our patients the expectation of payment for services rendered. Understanding your financial responsibilities is an integral part of your care and treatment.

Allergy and Asthma Relief Experts will submit charges for medical treatment to insurance companies and other third party payers. However, the patient or responsible party is contractually obligated to pay for all denied charges, non-covered charges, insurance co-payments and deductibles. We strongly encourage patients to contact their insurance companies to understand their benefit coverage, deductibles, co-payments and any prerequisites such as referrals, prior authorizations, etc. of their plan. We will provide information necessary for coverage determination to the patient upon the patient's request.

If patients are not covered by health insurance plans, the patient will be asked to pay a $100 deposit for the initial visit prior to the scheduled appointments. The deposit will be applied toward balances owed by the patient and any over-payment will be refunded.

Allergy and Asthma Relief Experts does treat worker's compensation injuries or illnesses with an authorized referral from your adjuster. We do not treat worker's compensation claims on a lien basis.

Failure to give 24-hour notice of cancellation of an appointment or not showing up for an appointment can result in a charge of $50.00 on your account. This charge is not covered by your insurance company and is your responsibility.

Medical record requests for personal use will be charged a fee of $25.00 up to 10 pages and 0.25 per sheet thereafter. Medical record requests made by other healthcare providers associated with a patient's medical care will be provided free of charge.

I understand that I am required to pay Allergy and Asthma Relief Experts for services received in accordance with this agreement. I agree to pay all amounts owed within 30 days from the billing date unless prior arrangements have been made with the office. Please feel free to call Sharon, our office manager to discuss other offered payment plans.

I authorize my health insurance company to make payments directly to Allergy and Asthma Relief Experts. I authorize Allergy and Asthma Relief Experts to release any information acquired in the course of my examination and treatment to my insurance company.

Patient or Responsible Party Signature _____ Date: _____

_____
Patient Printed Name

ALLERGY AND ASTHMA RELIEF EXPERTS

Adult, Pediatric Allergy & Immunology

Name: _____ **DOB:** _____

Reason for visit: _____

Previous doctors seen for this problem: _____

My general health is: (please circle): Poor Fair Good Very Good Excellent

Tobacco Use: _____ Never Smoked _____ Currently Smokes _____ Former Smoker

Do you have a history of any of the following:

	YES	NO
Unexplained fevers		
Weight changes		
Headaches (migraines/tension)		
Thyroid disease		
Diabetes		
Changes in vision		
Heart disease / heart attack		
Pacemakers or abnormal heart rhythm		
High blood pressure		
Lung disease (other than asthma)		
Gastrointestinal problems		
Hepatitis		
Urinary problems		
Pain or weakness of extremities		
Memory loss		
Easy bruising/bleeding		
Psoriasis		
Are you pregnant		

For anything answered "YES", please explain:

_____

_____

Please list all past surgeries (include dates):

_____

_____

Please list all medications you are currently taking:

_____

_____