ALLERGY AND ASTHMA RELIEF EXPERTS

PATIENT INFORMATION

(PLEASE PRINT) Today's Date:___________________

Patient's Name: ____Age: _____Gender _____DOB:_________________

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: ( ) _____-_________ Email: ________________________________

NOTICE: THE FOLLOWING QUESTIONS ARE INCLUDED TO COMPLY WTH 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 complete the information below.

Name of insured: _________________________Name of insurance company: ____________________

Subscriber ID# ___________________ Group # ______________________Do you have a deductible? _________

Insured Employed by: ____

Name of Preferred Pharmacy __________________________Telephone _______________

Address of Preferred Pharmacy: ____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

PCP/Referred Doctor: ______________________________Phone# ___________________

Address: ____________________________ City: ______________Zip: ___________

Referred by Friend: _________________________

Referred by Ins. Co: _____ Internet: _____ Other: ___________________

Emergency Contact: _____________________________________ Phone #: ( ) ________ - _______________

Relationship to patient: ____________________________________

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR JACOB OFFENBERGER, MD/ALLERGY AND ASTHMA RELIEF EXPERTS FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. 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 INSURANCE IS PROCESSED. PLEASE FEEL FREE TO DISCUSS ANY QUESTIONS REGARDING YOUR INSURANCE WITH OUR OFFICE MANAGER PRIOR TO YOUR VISIT.

24 HOUR NOTICE IS REQUIRED TO CANCEL ALL SCHEDULED APPOINTMENTS AND THIS OFFICE RESERVES THE RIGHT TO CHARGE $25 IF THIS REQUIREMENT IS NOT MET.

I understand and agree to the above statement:

Patient/Guardian Signature ____

ALLERGY AND ASTHMA RELIEF EXPERTS

ADULT, PEDIATRIC ALLERGY & IMMUNOLOGY

DATE:___________________

NAME: ____ **DOB:**___________________

REASON FOR VISIT: ____

PREVIOUS DOCTORS SEEN FOR THIS PROBLEM: ____

GENERAL HEALTH (PLEASE CIRCLE): POOR // FAIR // GOOD // VERY GOOD // EXCELLENT

TOBACCO USE (PLEASE CIRCLE): CURRENTLY SMOKING // FORMER SMOKER // NEVER

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING: (PLEASE CIRCLE)

UNEXPLAINED FEVERS	YES // NO
WEIGHT CHANGE	YES // NO
HEADACHES (MIGRAINES/TENSION)	YES // NO
THYROID DIEASE	YES // NO
DIABETES	YES // NO
CHANGE OF VISION	YES // NO
HEART DISEASE / HEART ATTACK	YES // NO
PACEMAKER OR ABNORMAL HEART RHYTHM	YES // NO
HIGH BLOOD PRESSURE	YES // NO
LUNG DISEASE (OTHER THAN ASTMA)	YES // NO
GASTROINTESTINAL PROBLEMS	YES // NO
HEPATITIS	YES // NO
URINARY PROBLEM	YES // NO
PAIN OR WEAKNESS OF EXTREMITIES	YES // NO
MEMORY LOSS	YES // NO
EASY BRUISING / BLEEDING	YES // NO
PSORIASIS	YES // NO
ARE YOU PREGNANT	YES // NO

FOR ANYTHING ANSWERED **"YES",** PLEASE EXPLAIN:

____

____

PLEASE LIST ALL PAST SURGERIES (INCLUDE DATES):

____

____

PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING:

____

____

ALLERGY and ASTHMA RELIEF EXPERTS

Jacob Offenberger, MD Cornelia DeLicona, MD Cecilia Euredjian, PA-C

A Specialty Medical Group

providing the highest quality care of asthma, allergies, and immune deficiencies

to adult and pediatric patients throughout the valley

10515 Balboa Blvd #390, Granada Hills, Ca 91344
Ph: 818 366-8112 Fax: 818 366-6002

27141 Hidaway Ave. #100, Santa Clarita, Ca 91351
Ph: 661 298-1491 Fax: 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 the 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-payment and deductibles. We strongly encourage patients to contact their insurance companies to understand their benefits 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 plan, the patient will be asked to pay $100 deposit for the initial visit prior to the schedule appointment. The deposit will be applied towards balance 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 $25.00 on your account. This charge is not covered by your insurance company and is your responsibility.

Medical record request for personal use will be charged a fee of $25 up to 10 pages and 0.25 cents per sheet thereafter. Medical records request 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 arrangement have been made with the office. Please feel free to call Pamela, our office manager to discuss other offered payment plans.

I authorized my health insurance company to make payments directly to Allergy and Asthma Relief Experts. I authorized 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: ______________________

Please Print Name: ____

ALLERGY AND ASTHMA RELIEF EXPERTS

Jacob Offenberger, MD

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ACKNOWLEDGEMENT RECEIPT OF
NOTICE OF PRIVACY PRACTICES
(You may refuse to sign this acknowledgement)

I, ____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

____
PLEASE PRINT NAME

____
SIGNATURE

____
DATE

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTIAN WRITTEN ACKNOWLEDGEMENT RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

_____ INDIVIDUAL REFUSED TO SIGN

_____ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

_____ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

_____ OTHER (PLEASE SPECIFY)

____
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