

Allergy Associates of Central IN LLC

D.B.A. Allergy, Asthma, Clinical Immunology Associates

Physician: _____ Account # _____ Date _____

Patient Registration

BILLING INFORMATION (Guarantor/Parent or Guardian of Dependent):

Name _____
First _____ Middle _____ Last _____
Address _____ Street _____ APT. _____ City _____ State _____ ZIP _____
Area Code & Phone Number _____ Cell Phone _____ Relationship To Patient _____

PATIENT INFORMATION:

Name _____
First _____ Middle _____ Last _____
ADDRESS: _____ Street _____ APT. _____ City _____ State _____ ZIP _____
Area Code & Phone Number _____ Emergency Contact Person _____ Emergency Contact Phone Number _____
DOB _____ / _____ / _____ Male or Female _____
Month Day Year Marital Status _____ Social Security # _____ Cell Phone _____
Primary Care Physician _____ Referral required from PCP? Yes NO Referring Physician if different _____
Employer Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____ Ext. _____

PRIMARY INSURANCE: *Must be completed in full along with a photo copy of the insurance card. EFFECTIVE DATE: _____

Insurance Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____
GROUP # _____ POLICY # _____ Relationship to Subscriber: _____
Subscriber Name _____ DOB _____ SS# _____
Employer Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____ Ext. _____

SECONDARY INSURANCE: * Must be completed in full along with a photo copy of the insurance card. EFFECTIVE DATE: _____

Insurance Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____
GROUP # _____ POLICY # _____ Relationship to Subscriber: _____

*Patients with MEDICARE as a secondary payor must provide the reason why Medicare is a secondary policy for the patient. Please CIRCLE one of the reasons below:
(12) Working Age Beneficiary/Spouse with Employer Group Health Plan (13) End Stage Renal (14) No Fault Insurance (15) Worker Compensation
(41) Black Lung (42) VA Veterans Administration (43) Disabled Beneficiary under 64 with Group Health Plan (47) Any other Liability Insurance

Subscriber Name _____ DOB _____ SS# _____
Employer Name _____ Address _____ City _____ State _____ ZIP _____ Phone _____

APPLIES TO MEDICARE PATIENTS ONLY: I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to provider for any services furnished me by their physicians. I authorize my holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. APPLIES TO MEDIGAP PATIENTS ONLY: I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to provider for any services furnished me by their physicians. I authorize any holder of medical information about me to release to my _____ insurance any information needed to determine these benefits payable for services.

(Insurance Co. Name)

ALL PATIENTS and/or GUARANTOR: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to Provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect until such time as revoked by me. In the case of default payment, I promise to pay any legal interest on the balance due together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature of Patient or Guarantor _____ Date _____