WELCOME TO ASTHMA & ALLERGY CENTER
303 E. ARMY TRAIL ROAD, SUITE 403
BLOOMINGDALE, IL 60108
Greg E. Sharon M.D. Priya J. Bansal M.D.
PHONE: 630-894-7083 FAX: 630-894-9472

Please complete the following form for each patient. The following information is necessary for ALL patients. If you need help with the form, the Receptionist will be happy to help you. Please present *your* ***insurance card and a photo I.D.*** to the Receptionist with this completed form. Thank You!

PATIENT INFORMATION

Last Name: _____First Name: _____ Middle Initial: _____

Address: _____City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____ Birth Date: _____ Sex: M F Marital Status: S M D Sep W

Social Security No.: _____ Race: _____Ethnicity:_____

Spouse's Name: _____ Work No.: _____

Emergency Contact: _____Phone: _____Relationship: _____

Primary Care Physician (Phone and/or Address):_____

Referral Physician (Phone and/or Address):_____

Pharmacy:_____Phone:_____Address:_____

RESPONSIBLE PARTY'S EMPLOYER

Employer Name: _____

Address: _____City: _____State: _____ Zip: _____

PRIMARY CARD HOLDER ON INSURANCE

Name: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

Social Security No.: _____ Birth Date: _____

Relationship to Patient: _____

Notice of Privacy Practices

To our patients; this notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests. **Is it acceptable to leave lab and radiology results on your phone answering system? □ Yes □ No**
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, **you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends.** We are not required to agree to your request; however, if we do agree, we are bond by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Asthma and Allergy Center.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Asthma and Allergy Center. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our office.
6. Right to file a complaint. If you believe your rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office manager.

I hereby acknowledge that I have been presented with a copy of Asthma and Allergy Center's Notice of Privacy Practice.

You will Sign This at Your First Visit, This Is a Copy For Your Records

Asthma and Allergy Center
Patient Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. The following information is to familiarize you with our billing policies:

- Full payment for professional services is due at time of service. As a courtesy to our patients Asthma and Allergy Center will bill your insurance company. Any co-pays and deductibles are due prior to treatment.
- If your insurance company was billed and payment is not received within 45 days, the balance will be transferred to the patient's responsibility. It is the patient's responsibility to obtain payment from the insurance company or negotiate a settlement on any disputed claim. Any portion of the bill not paid, or denied, by the insurance carrier, will be the patient's responsibility.
- You must inform our office if you have a new insurance carrier or if the insurance carrier has located to a new address. Please send us a copy of the front and back of your new insurance card so we can update our records. In the event that you're insurance coverage or our plan participation changes to a plan where we are not participating providers, you will be responsible for payment of all fees at the time service is rendered.
- We DO NOT bill secondary insurance carriers unless Medicare is your secondary insurance or we are contracted with the secondary insurance carrier. Use the Explanation of Benefits (EOB) from your primary insurance carrier and the statement of services provided at your visit to bill your secondary insurance.
- Upon receipt of payment from your insurance company, you will receive a statement showing your balance due. Payment is expected within fourteen (14) days. For your convenience, we accept Visa, MasterCard, and Discover.
- If payment, IN FULL, is not received, you will be charged a $20 re-billing fee each time we issue you a statement on an outstanding balance over 30 days.
- In the event your bill is not paid and is turned over to our professional collection agency, Transworld Services you will be charged an additional 25% of your outstanding balance. Also information will be given to them and may include, but is not limited to, your name, address, phone number, social security number, employment and employment phone number.
- Full payment for services associated with a motor vehicle accident (MVA) or Workers Compensation (WC) claim are due at time of service. Usually these claims are not paid by your regular health plan and must be submitted to the responsible party for payment. We will provide you with a HCFA 1500 form that you can use to submit for reimbursement. However, if our physicians participate in your regular insurance plan, we will submit your claim to the third party carrier for payment. Please provide us with the third party billing information at time of service. If timely payment is not received by the WC or MVA carrier, we will bill your health insurance.
- Additional fees may be assessed for the following: Forms completion, Medical Records, Phone Consultations, Appt cancellations within 24 hours.
- This office reserves the right to change its fees at any time without prior notice.

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I understand and agree, (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information in this packet and have also completed the questions; I certify this information is true and correct to the best of my knowledge. I will notify Asthma and Allergy Center of any changes in my health status or any of my information including but not limited to insurance, address, and phone numbers.

I hereby authorize my insurance benefits be paid directly to Asthma and Allergy Center and I am responsible for non-covered services. I also authorize Asthma and Allergy Center to release any information required to process my claims. I also authorize the transfer of medical records via fax, if it is needed to provide immediate care.

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