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Allergy & Asthma SPECIALISTS of NORTH FLORIDA, P.A.

Trusted expertise in allergy and asthma care for infants, children and adults.

BOARD CERTIFIED
ALLERGY & IMMUNOLOGY
CHILDREN AND ADULTS

Patient name:_____ **DOB:**_____

Name of parent or legal guardian (if applicable):_____

Thank you for choosing Allergy & Asthma Specialists of North Florida for your allergy and asthma needs. We value the trust you have placed in our care and are committed to providing you with the highest level of medical expertise. Our practice firmly believes that a good physician-patient relationship is based on mutual respect, understanding and good communication. The following information is provided to help avoid any misunderstandings about issues that may arise regarding our office policies. Please take time to read each section carefully. By signing below you acknowledge that you agree to the stated policies. Questions about financial arrangements should be directed to the billing office. If you have special needs, we will make every effort to work with you.

Welcome to our practice and we look forward to assisting you with your medical care!

FINANCIAL POLICY

Since professional services are rendered to me and not my insurance company, I understand that I am directly and primarily responsible to pay the amount of all allowable charges incurred for services and procedures rendered by Allergy & Asthma Specialists of North Florida, P.A (AASNF). I am responsible for any applicable deductable or co-payments prior to the provision services. AASNF may file a claim for payment with my insurance company as required by contractual agreement. I understand that if my insurance company fails to pay AASNF within 60 days, my balance will be transferred to self-pay and I will be responsible for immediate payment of all the remaining, allowable amounts owed to AASNF. **Collections:** Should my account be referred to a collection agency or an attorney due to delinquency, I will be responsible for all fees incurred. The customary collection fee is 30% of the outstanding balance.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE, PHOTO ID AND OBTAIN REFERRAL

I understand that is it my responsibility to provide AASNF with a copy of my current insurance card, photo identification and to obtain a referral from my Primary Care Physician (if required by my insurance). AASNF is not obligated to see patients without the above documentation. If I would like to be seen without documentation of insurance coverage, I agree that a claim for the visit will not be filed with my insurance carrier and I will be required to pay the total cost in advance to be seen by the doctor. If I do not have insurance, I will be considered a Private Pay (or self pay) patient and I am financially responsible for the total amount of services provided. I will notify AASNF immediately upon any change in my insurance.

NON-COVERED SERVICES WAIVER

The office staff will make every reasonable effort to work with my insurance company to ensure that I receive the maximum reimbursement to cover the cost of my treatment. However, there may be a service I desire or is suggested/provided that is not covered, or only partially covered, under my insurance plan ("Non-Covered Services"). In the event that my insurance company refuses to authorize these services as medically necessary, I will be responsible for all charges associated with this service.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payment/ insurance benefits for medical services and or procedures rendered, directly to AASNF. I hereby authorize AASNF to release medical information necessary to obtain payment and to appeal any claims in dispute for non-payment or lesser payment. I understand that I am financially responsible for all allowable charges not covered by my insurance plan.

PAYMENT INFORMATION

AASNF accepts cash, checks, and credit cards. I understand a $25 charge will be applied to my account for returned checks. In the event I receive payment from my insurance carrier, I will issue payment to AASNF.

APPOINTMENT CANCELATION POLICY AND FEES

If you are unable to keep your scheduled appointment, please call to cancel your appointment in a timely manner. Doing so will afford our staff the opportunity to schedule another patient in your place who is in need of medical care. I understand that I am financially liable for a $35.00 non-cancelation fee if I fail to cancel within 24 hours of a scheduled appointment. This fee is not covered by insurance. I also understand that I may be asked to reschedule if I do not arrive on time for my appointment.

SIGNATURE:_____ **DATE:**_____

PRESCRIPTION AND REFILL POLICY

AASNF may obtain medication information electronically from local and mail-order pharmacies in order to assist with the accuracy of your medications. Additionally, we make every effort to send prescriptions electronically to your pharmacy at time of your office visit. For refill requests, please contact your pharmacy first as this will help to expedite the process. Routine refills may take 48-72 hours to be processed by our office. PLEASE NOTE THAT REFILLS WILL NOT BE HANDLED AFTER OFFICE HOURS.

LAB SERVICES

Labs may be drawn as a courtesy at the time of visit. We are unable to guarantee payment of lab services by your insurance carrier. It is your responsibility to contact your insurance company prior to having labs drawn should you have questions or concerns regarding insurance coverage.

MEDICAL RECORD FEES

When copies of medical records are requested, I will be required to sign a release of information. The cost of reproducing copies (in accordance with Florida law) will be $1.00 per page for the first 20 pages. In the event that there are more than 20 pages, there will be an additional charge of 25 cents per page. Please allow 72-96 hours for preparation of the copies.

MISCELLANEOUS SERVICES

Since your primary care provider has access to more complete medical records and has a more extensive knowledge of all of your medical conditions, every effort should be made to have him/her complete any forms (e.g. insurance, disability, FMLA paperwork, etc.). In the rare case that the provider will be unable to do this, there will be a $50 charge for the completion of these forms by one of our physicians and is not covered by medical insurance. An exception to this would be school forms allowing a child to have an allergy or asthma related medication at school or daycare. We will make every effort to complete these forms as quickly as possible but these services may take up to 7 business days to complete due to the high volume of requests.

CONSENT FOR MEDICAL PHOTOGRAPHY

Allergy & Asthma Specialists of North Florida, P.A. is dedicated to the prevention of medical errors and providing state-of-the-art care. In order to reduce the risk of patient misidentification, you may be asked to have your photograph taken. The photo will be placed in your secure electronic health record and on your allergy shot card (if you are a candidate for allergen immunotherapy). Photographs of rashes or swelling will assist with comparing the progression of disease and response to therapy between office visits. All images will be used for medical record purposes only. Refusal to consent to photographs will in no way affect the medical care that you will receive.

I agree that medical photographs may be taken of myself or my child (or person for whom I am a legal guardian) for the documentation of medical conditions and identification purposes only. I also agree that the images may be shared with my (or my child's) referring/treating physician(s).

Initials_____

OR:

I DO NOT give permission for medical photography to be taken of me/my child or legal dependent. **Initials**_____

I have carefully read and understand each section of the Allergy & Asthma Specialists of North Florida, P.A. patient information form and agree to each of the stated policies contained within.

PATIENT SIGNATURE (responsible party if minor):_____

PRINTED NAME: _____ **DATE:**_____

Employee's signature reviewed intake form:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS AND PRACTICES

You may refuse to sign this acknowledgement

I, _____ have been given the opportunity to read a copy of this office's
(printed name)

'Notice of Privacy Rights and Practices' document accessible on the practice's website and available in the office.

I authorize Allergy & Asthma Specialists of North Florida, P.A to discuss my personal health information (e.g. labs, X-ray reports, etc.) with me and with those authorized by me (as listed below) by way of mail and telephone including, voicemail, answering machine, and text message by using the telephone number(s) which I have provided. Additionally, my information may also be posted to a secured patient portal or via an encrypted e-mail for my review.

_____ _____
Signature **Date**

Name(s) of individuals to whom my Protected Health Information (PHI) may be released or discussed with either in person, by telephone, or by mail*:

1. _____ _____
Name Date of Birth

2. _____ _____
Name Date of Birth

*Please note that proper identification must be provided when picking up records or discussing PHI on your behalf.

**********FOR OFFICE USE ONLY**********

We attempted to obtain written acknowledgement of 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): _____

Allergy & Asthma Specialists of North Florida complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Allergy & Asthma Specialists of North Florida cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo

Allergy & Asthma Specialists of North Florida konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

TAL 3/18