REGISTRATION FORM
ALLERGY, ASTHMA, AND SINUS CENTER, PLLC
1136 MONARCH ST LEXINGTON, KY 40513
PH: (859)223-0000 FAX: (859)223-0602

EMAIL ADDRESS (FOR ACCESS TO PATIENT PORTAL)_____

LAST NAME: _____ MI: ____ FIRST: _____

GENDER: M / F SSN: _____-____-_____ DOB: ____/____/_____

ADDRESS: _____ CITY: _____ ST/ZIP: _____

HOME PHONE: _____ WORK/CELL: _____

RACE/ETHNICITY: _____ PREFERRED LANGUAGE: _____

EMERGENCY CONTACT NAME: _____

RELATION TO PATIENT: _____ PHONE: _____

MAY WE CONTACT YOU BY PHONE AND LEAVE A MESSAGE ON YOUR VOICE MAIL? YES_____ NO_____

MAY WE TEXT YOU TO REMIND YOU OF YOUR APPOINTMENTS? YES_____ NO_____

PRIMARY CARE PHYSICIAN: FIRST NAME: _____ LAST NAME: _____

REFERRING PHYSICIAN (IF DIFFERENT): FIRST NAME: _____ LAST NAME: _____

IF PATIENT IS UNDER THE AGE OF 18:

MOTHER: _____ DOB: ____/____/____ SSN: _____-____-_____

ADDRESS (IF DIFFERENT): _____ CITY: _____ ST/ZIP: _____

FATHER: _____ DOB: ____/____/____ SSN: _____-____-_____

ADDRESS (IF DIFFERENT): _____ CITY: _____ ST/ZIP: _____

** THE POLICY HOLDER'S DATE OF BIRTH AND SOCIAL SECURITY NUMBER IS REQUIRED**

PRIMARY INSURANCE CO: _____

POLICY HOLDER'S NAME: _____ RELATION TO PATIENT: _____

POLICY HOLDER'S DOB: ____/____/_____ POLICY HOLDER'S SSN: _____-____-_____

MEMBER ID: _____ GROUP: _____ CO PAY: $_____ EFFECTIVE_____

SECONDARY INSURANCE CO: _____

POLICY HOLDER'S NAME: _____ RELATION TO PATIENT: _____

POLICY HOLDER'S DOB: ____/____/_____ POLICY HOLDER'S SSN: _____-____-_____

MEMBER ID: _____ GROUP: _____ CO PAY: $_____ EFFECTIVE_____

Allergy, Asthma & Sinus Center, PLLC
Arun Kadambi,M.D.
1136 Monarch Street, Lexington KY 40513
859-223-0000 (phone) 859-223-0602 (fax)

Financial Policy and Payment Agreement

Thank you for choosing Allergy, Asthma & Sinus Center, PLLC. Please read and sign the following statements regarding our financial and insurance policies.

If you have health insurance, we will file your insurance claims one time. You must bring your insurance card, referral form (if applicable), and necessary co-payments/co-insurance to every appointment. Please understand that insurance is an agreement between you and your insurance carrier, and that we are not part of that agreement. We suggest you contact the customer service telephone number listed on the back of your insurance card to understand what your policy covers. If you have more than one insurance, you are responsible to identify the order your insurance is to be billed.

Please be aware that we require a 24 hour notice for cancelled or rescheduled appointments. You will be required to pay a **$25 cancellation fee** if you fail to cancel or reschedule your appointment prior to 24 hours before your scheduled appointment.

We gladly accept cash, checks, credit cards and Care Credit. Should you need to discuss your bill, please contact our billing office at 859-223-0000. We are more than willing to work with you to resolve your balance; however, delinquent accounts will be referred to a credit bureau for collections.

In case of default of payment, the patient or responsible party agrees to pay all costs of collections including attorney fees, collection fees, and contingency fees to the collection agencies up to 40%, with such contingency fees to be added and collected by the collection agency. In the case of a court action, the patient or responsible party is responsible for any court costs, serving fees, or attorney fees.

Release of Information, Benefit Assignment, Payment Authorization, Full Disclosure Statement, Payment Agreement and Permission to Treat.

I hereby authorize Allergy, Asthma & Sinus Center to release any information necessary to my insurance company or billing agency to fulfill my financial responsibility. I authorize my insurance carriers to issue payments directly to Allergy Asthma & Sinus Center. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred. I agree to pay such fees in full within 30 days of receiving a patient statement. I have received a copy of the "Notice of Privacy & Policy Practices". I hereby give my permission to accept medical care by the providers and clinical staff of Allergy, Asthma & Sinus Center.

_____ _____

Patient/Responsible Party Signature Date

_____

Print Patient/Responsible Party Name

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than a 24 hour notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than a 24 hour notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification will be subject to a **$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel will be considered as **NO SHOW**. Patients who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice and will be denied any future appointments. Patients will be subject **to a $25.00 fee for office appointment No Show. If an interpreter was scheduled to assist the patient during the appointment a $55.00 fee for office appointment No Show will be charged.**

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (859) 223-0000.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ _____

Patient Name (Please Print) **Date of Birth**

_____ _____

Signature of Patient or Patient Representative **Date**

Allergy, Asthma & Sinus Center

Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Allergy, Asthma & Sinus Center to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient: _____

2._____ Relation to Patient: _____

3._____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the recipient.

You have the right to revoke this consent in writing.

Signature: _____Date: _____

INFORMED CONSENT FOR TELEMEDICINE SERVICES

PATIENT NAME: _____

DATE OF BIRTH: _____ CHART NUMBER: _____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Allergy, Asthma and Sinus Center providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, my insurance carrier will have access to my medical records for quality review/audit.

I understand that my insurance carrier will be billed and I will be responsible for any copayments, coinsurances or deductibles that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Allergy, Asthma and Sinus Center. As long as consent is in force (has not been revoked) Allergy, Asthma and Sinus Center may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to patient: _____

Witness: _____ *Date:* _____

I have been offered a copy of this Consent Form (patient's initials) _____

Please stop taking the following medications for the amount of time specified.

- Claritin/Loratidine – 5 Days Prior
- Xyzal /Levocetirizine – 5 Days Prior
- Allegra/fexofenadine – 5 Days Prior
- Zyrtec/Cetirizine – 5 Days Prior
- Clarinex/Desloratidine – 5 Days Prior
- Amitriptylline – 5 Days Prior
- Any over the counter cold and cough, sinus medication such as Tylenol Cold and Sinus, Dimetapp
- Certain antidepressants (Elavil, Sinequan (Doxepin), Imipramine) – 5 days
- Other Antihistamines:Benadryl (dyphenhydramine), Atarax (hydroxyzine), Phenegran (Promethazine), Dallergy, Bromfed, Chlor-Trimeton, & Actifed, etc – 3 days
- Over-the-counter sleeping medication – 3 days
- Other drugs to avoid for 48 hours prior to appointment: Zantac (Ranitidine), Pepcid (famotidine) and Tagament (Cimetidine HCl)
- All other medications including other antidepressants not listed above should be continued as prescribed. If you have any questions regarding a specific medication, please consult your pharmacy or prescribing provider.

Please visit our website at www.aasclex.com to print all new patient paperwork and to get directions to our offices.

Lexington Office
1136 Monarch Street
Lexington, Kentucky 40513
(859) 223-0000

Danville Office
504 Tenikat Street
Danville, Kentucky 40422
(859) 223-0000

London Office
1308 S Main Street
London, Kentucky 40741
(859) 223-0000

Any questions or if you need to reschedule please call (859) 223-0000