FAMILY ALLERGY & ASTHMA CONSULTANTS, PA
SUDHIR PRABHU, M.D. SUNIL JOSHI, M.D. MIKE MASS, M.D. HARY KATZ, M.D.
4123 University Blvd. S., Suite B, Jacksonville, FL 32216
(904) 636-9100

Acquaintance Information

Date: _____

Patient's Name: _____
First Middle Last

Address: _____
Number Street Apt# City State Zip

Date of Birth _____ **Sex: M ( ) F ( )** **Marital Status: M ( ) S ( )**

Drivers License Number _____

Home Phone ( ) _____ **Cell Phone ( )** _____

Email address _____

Pharmacy: Street Name and Phone Number: _____

Patient's Employer (If patient is a minor, Father's Name) _____

Employer's Name _____ **Business Phone** _____

Spouse's Name (If patient is a minor, Mother's Name) _____

Employer's Name _____ **Business Phone** _____

Preferred Telephone Number To Be Contacted At: _____

How did you hear of this office:

A. Doctor ___ If so, was it your PCP ____ If no, doctor's name: _____
B. Friend/Relative ___ If so, their Name: _____
C. Website _____
D. Hospital or other Organization Referral Service ___ If so, which one? _____
E. Yellow Pages: AT&T ___ Talking Phone Book ___ Unsure ___
F. Yellow Pages.com ___ Google ____ other internet search ___ which one _____
G. WJCT ____ Other broadcast _____ If other, which one _____
H. Other ___ If so, please list source _____

Patient's Primary Care Physician _____

_____
Name and Phone Number of Relative Not Living at the Same Address

Any Known Drug Allergies _____

BILLING/PAYMENT POLICY

As part of our efforts to offer improved and convenient service to our patients, we have established a billing policy. Please spend some time to familiarize yourself with it.

Payment is due at the time of service, as per the following guidelines, by either check or credit card.
WE DO NOT ACCEPT CASH.

HMO/PPO Policies: We will follow the copay, co-insurance and deductible guidelines for your HMO/PPO policy. If your insurance policy is an HMO, which requires a referral, we must have either a written referral or a referral number before your visit or you will be responsible for payment in full at the time of service.

Indemnity Policies: We will file with your insurance company, less and deductible or co-insurance which will be payable at the time of service, for all services except for those related to follow up care/visits. Kindly note that we file with your insurance company as a courtesy to you. However each patient is ultimately responsible for the satisfactory payment of all fees incurred in relation to the services provided to him/her. Any outstanding balance 6 weeks after we have billed your insurance company is payable by you. We recommend that you follow up with your insurance company at regular intervals to avoid being billed.

Please note that any services which are not covered by your insurance policy are payable at the time of service.

We cannot coordinate benefits between multiple policies (Exception – Medicare recipient)

I have read and agree to the above billing policy: _____

Patient/Guardian's Signature Date

AUTHORIZATIONS

I authorize the Family Allergy & Asthma Consultants to release all or portions of its files regarding myself/the patient to other physicians who provide services for my/the patient's care, to insurance companies for the purposes of processing claims, and to interested government agencies including Medicare and Medicaid.

We hereby irrevocably assign to the clinic all benefits to which the patient or I am entitled, including Medicare and Medicaid benefits, if applicable, and insurance proceeds. I authorize the clinic to act as agent for us and for the patient to collect insurance proceeds and we authorize the insurance carrier to pay all insurance benefits directly to the clinic.

_____

Patient/Guardian's Signature Date

NON-COVERED SERVICES AGREEMENT

Our staff will make every effort to assist you with your insurance company to ensure that your treatment is authorized and you receive maximum reimbursement to cover the cost of your treatment. In the event your company refuses to authorize your care as medically necessary, you will be responsible for all charges associated with your care.

I understand that if my insurance company refuses to authorize my care for any reason, that I will be responsible for all charges and payments for services rendered. Charges will reflect usual and customary rate for services.

_____

Patient/Guardian's Signature Date

CANCELLATION POLICY

If in the event you have to cancel or reschedule an appointment, we require 24-hour advance notice.

_____

Patient/Guardian's Signature Date

MEDICAL FORM FEES

In the event that you need copies of your medical records, a letter from the doctor, or forms filled out, there is a fee for these additional services. The fees vary and we will notify you of the exact cost, depending upon your specific need. These services take up to 7 to 10 working days to complete due to high volume of requests.

Patient/Guardian's Signature Date

CONSENT TO TREAT A MINOR

I, _____ (Parent/Guardian) do hereby authorize Allergy, Asthma & Immunology to provide service to _____ (a minor under 18 years of age) with or without my presence.

Parent/Guardian's Signature Date

PRESCRIPTION REFILL POLICY

Prescriptions will be refilled within 48 hours of request. We prefer that the pharmacy contact us with refill requests rather than the patient, as this helps expedite the process. PLEASE NOTE THAT REFILLS WILL NOT BE HANDLED AFTER HOURS.

Patient/Guardian's Signature Date