Consultants In Asthma, Allergy & Immunology, P.A.

Peter Benincasa, M.D. Richard E. Luka, M.D

Form Rev 9/2018

Date:	Patient Last Name, First Name & Middle Initial	Date of Birth	Age	Social Security Number

Patient Address

Town State Zip

Patient Home Phone Number	Patient Work Number Ext	Patient Cell Phone Number

Please indicate preferred contact number:

☐ Home ☐ Work ☐ Cell

Email:

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ White ☐ Other ☐ Unknown ☐ Prefer not to answer

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other ☐ Prefer not to answer

Preferred Language:

☐ English ☐ Spanish ☐ Other

Patient Relationship To Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient is:

☐ Single ☐ Married ☐ Widowed ☐ Other

Patient Sex:

☐ Male ☐ Female

Employer Name:

Occupation/Title:

Emergency Contact:	Telephone Number	Relationship

How did you hear of our practice?

☐ Doctor Name: _____

☐ Family/Friend ☐ Insurance ☐ Internet ☐ Returning Patient ☐ Social Media ☐ Street Sign/Ad ☐ Yellow Pages

Please list other family members who have been seen at the practice:

INSURANCE INFORMATION – THIS SECTION MUST BE FULLY COMPLETED

Name of Primary Insurance Carrier	Policy Number	Group Number	
Policy Holder Name on Primary Plan	Policy Holder Date of Birth (REQUIRED)	Referral Required? ☐ Yes ☐ No	Specialist Copay $
Name of Secondary Insurance Carrier	Policy Number	Group Number	
Policy Holder Name on Secondary Plan	Policy Holder Date of Birth (REQUIRED)	Referral Required? ☐ Yes ☐ No	Specialist Copay $

PHYSICIAN & HEALTHCARE INFORMATION

Name & Address of Primary Care Physician/Pediatrician

Name of Referring Physician:

Preferred Pharmacy	Tel Number	Town

I acknowledge receipt and understand the HIPAA privacy laws as they pertain to Consultants In Asthma, Allergy & Immunology,P.A.

Patient/Guardian Signature _____ Date: _____

GUARANTOR FINANCIAL AGREEMENT

I authorize the release of information necessary to any entities to secure the payment of benefits submitted for services rendered by Consultants In Asthma, Allergy & Immunology, P.A. on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service, Advanced Electronic Medical Billing, Inc., to secure the payment of benefits. I further agree and acknowledge that my signature on this document authorizes claims to be submitted for benefits for any services rendered without obtaining my signature on every claim form. I assign directly to Consultants In Asthma, Allergy & Immunology, P.A. insurance payments for all services rendered. Should the need arise, I also authorize Consultants In Asthma, Allergy & Immunology, P.A. and Advanced Electronic Medical Billing, Inc., to file a complaint on my behalf for any dispute/appeal regarding fair payment.

I understand I am financially and fully responsible for all charges incurred if my insurance carrier denies payment for any reason. I understand I will be financially responsible for any deductibles, coinsurance or co-pays according to my benefit plan. I understand that a co-payment is due at the time of service. I understand that a delinquent balance must be paid in full prior to any scheduled appointments, unless prior payment arrangements have been made. I understand I am responsible for contacting my insurance carrier prior to services rendered, to determine participation, referral or pre-authorization requirements, and coverage limits. If my plan requires a referral, it is my responsibility to understand and obtain this requirement prior to any office visits. In the event my insurance carrier issues a payment directly to me, I agree to immediately reimburse Consultants In Asthma, Allergy & Immunology, P.A.the same amount in addition to any co-pays, deductibles or coinsurances due based on the explanation of benefits, which must be sent along with my payment.

I agree to provide Consultants In Asthma, Allergy & Immunology, P.A. with current insurance information and notify the office of any changes within 30 days from my visit. I understand that if a claim is not paid because of my failure to provide the correct insurance information in a timely manner, I am fully responsible for the charges. In the event my insurance carrier requests a coordination of benefit update or additional information from me before payment is made, and it is not provided in a timely manner, I understand I will be responsible for any outstanding balances. I understand that payment is due upon receipt of my monthly statement, which will reflect a brief description of services provided. I understand that I may be legally responsible for all collection costs involved including attorney's fees that are 1/3 of all balances due and owing, collection filing fees, and any fees for returned checks. Any credits will remain on your account and will be applied to future balances, unless you contact our billing department and request a refund in writing.

This agreement has no term date and will remain in force until such time as a new agreement is signed.

PATIENT /GUARANTOR SIGNATURE (Must be 18 Years of Age) **Date:**

Please print full name:		**Daytime Telephone:**
Please print full mailing address:		
Town	**State**	**Zip code**

CONSULTANTS IN ASTHMA, ALLERGY, AND IMMUNOLOGY

PETER BENINCASA, M.D., and RICHARD LUKA, M.D.

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Fax: 973.478.2290	Fax: 973.470.9858	Fax: 732.388.2233

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I, _____ acknowledge that I have received a copy of Consultants in Asthma, Allergy and Immunology's Notice regarding Privacy of Personal Health Information.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date