Allergy & Asthma Clinic of Maryland
8630 Fenton St, Ste 522, Silver Spring, MD 20910
Phone: (240) 531-2902 Fax: (240) 847-7061

PATIENT REGISTRATION FORM

DATE: _____

NAME: _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY: _____- _____ - _____ **SEX**:[M][F] **MARITAL STATUS**:[M][S][W][D]

IF ***UNDER 18,*** NAME OF PARENTS/GUARDIANS: _____

PARENT/GUARDIAN DATE OF BIRTH: _____ SOCIAL SECURITY: _____-____-_____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP:** _____

HOME ( ) _____ **CELL** ( ) _____ **WORK** ( ) _____

EMAIL: _____

Preferred method of contact □ Home Phone □ Cell Phone □ US Mail □ Email

YES NO I authorize the Allergy & Asthma Clinic of Maryland PLLC to leave a recorded message at my preferred method of contact (listed above) in order to reach me about my care.

YES NO I authorize Allergy & Asthma Clinic of Maryland, PLLC, to speak with the following person about my medical condition and associated care:
Name: _____ Relation _____

EMERGENCY CONTACT _____ **PHONE** _____

PRIMARY INSURANCE COMPANY: _____ □ MEDICAID

CONTRACT NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER DOB: _____ SOC. SEC. #: _____- _____ - _____

SECONDARY INSURANCE COMPANY: _____ □ MEDICAID

CONTRACT NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER DOB: _____ SOC. SEC. #: _____- _____ - _____

THE FOLLOWING QUESTIONS ARE <u>OPTIONAL</u>

RACE: _____ ETHNICITY: _____

PRIMARY LANGUAGE: ENGLISH OTHER _____

Office Use Only Patient Account Number _____
Updated in Module MD _____

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FINANCIAL POLICY

Providing quality medical care for our patients is the primary goal of Allergy & Asthma Clinic of Maryland, PLLC (AACOM). AACOM employees will gladly answer questions you may have about insurance and payment information, however it is your responsibility to confirm all insurance information with your insurance carrier. Please verify with your insurance carrier which benefits are covered pertaining to allergy services, specialty visits, and which providers are considered in-network or out-of-network.

Should your insurance company require a referral from your primary care physician before you can be seen by our providers, it is your responsibility to obtain that referral prior to your appointment. Please bring the referral with you to your appointment. If your insurance carrier does require a referral, but you fail to obtain one prior to your appointment, AACOM will be unable to bill your insurance and you will be billed for services instead. If you are seen without a referral, you must be prepared to pay for all services in full at the time they are rendered. If a referral is required by your insurance carrier and you are unsure as to how to obtain one, please let the staff know and we will be happy to provide assistance.

If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day, or if your contract contains a pre-existing clause, your insurance carrier will most likely deny payment for services received. Please remember that you, the patient, are ultimately responsible for payment on your account.

By signing below, you are acknowledging understanding and agreement with the following financial policy:

I authorize the rendering of care to me or my child by the providers of Allergy & Asthma Clinic of Maryland, PLLC. I also authorize any hospital, physician or their agents to release to any insurance carrier or any of their agents, all medical records or information deemed necessary to determine the benefits payable for any/all related medical services provided by the providers at Allergy & Asthma Clinic of Maryland, PLLC. I authorize the providers at Allergy & Asthma Clinic of Maryland, PLLC to release any and all medical records or information they deem necessary to any physician, hospital or other supplier who has, or will, participate in my medical care either in the past, present or at some time in the future. I further authorize any insurance carrier to pay the total sum of my medical benefits directly to Allergy & Asthma Clinic of Maryland, PLLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay for all services that are not covered by my insurance at the time services are rendered.

PATIENT/GUARDIAN SIGNATURE_____ **DATE:** _____

No Show Policy

Allergy and Asthma Clinic of Maryland, PLLC is committed to helping you manage and maintain your healthcare needs. When you schedule an appointment with one of our physicians that time is reserved exclusively for you to discuss and review your medical concerns. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office **24 hours in advance.** Providing our office with adequate notice will allow us to offer that appointment time to another patient who needs to see the physician.

The following no-show and/or late cancellation fees will be assessed: A **$50** charge will be assessed for "no showing" or for failing to give 24-hour notice of the need to cancel all scheduled new patient appointments.*These charges are not billable to your insurance and will ultimately be the responsibility of the patient. All no-show charges will need to be paid before your next appointment with the physician.*