ALLERGY & ASTHMA CARE, P.A.
10787 Nall Ave., Ste. 200
Overland Park, KS 66211

Patient Information Sheet

Today's Date _____/_____/_____

Patient's Name (Last) _____ (First) _____ (MI) _____

Maiden/Nickname _____ Date of Birth _____/_____/_____ Gender: ☐ Female ☐ Male

Street Address _____ Apt _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Phone Numbers (Home) _____ (Work) _____ Ext _____ (Cell) _____

Email Address _____ @ _____ . _____

Ethnicity: ☐ Caucasian/White ☐ African American/Black ☐ Hispanic/Latino ☐ Asian ☐ Other

Social Security Number _____-_____-_____ Driver's License _____ State _____

Primary Care Physician _____ Referred By _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Active Military ☐ Student ☐ Retired

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Spouse's Name (First and Last) _____ Date of Birth _____/_____/_____

Spouse's Phone Number _____ Spouse's Work Number _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Active Military ☐ Student ☐ Retired

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

If Patient is a MINOR, please complete the following section:

Parent 1: ☐ Dr. ☐ Miss. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Rev.

Name (First and Last) _____ Maiden Name _____

Address _____ Apt _____ City _____ State _____ Zip _____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____ @ _____ . _____

Parent 2: ☐ Dr. ☐ Miss. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Rev.

Name (First and Last) _____ Maiden Name _____

Address _____ Apt _____ City _____ State _____ Zip _____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____ @ _____ . _____

Emergency Contact

☐ **Mark here if same as Parent** ○ Parent 1 ○ Parent 2 ○ Spouse

Name (First and Last) _____ Relation to Patient _____

Address _____ Apt _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Ext. _____ Cell _____

PLEASE COMPLETE INSURANCE INFORMATION ON REVERSE SIDE

Primary Insurance Information (please provide a copy of your insurance card)

Insurance Company _____ Policy Holder's Name (First and Last) _____

Policy Holder's DOB _____ /_____/ _____ Policy Holder's Social Security Number _____-_____-_____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Effective Date of Policy _____

Member ID Number _____ Group/Account Number _____

Secondary Insurance Information (please provide a copy of your insurance card)

Insurance Company _____ Policy Holder's Name (First and Last) _____

Policy Holder's DOB _____ /_____/ _____ Policy Holder's Social Security Number _____-_____-_____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Effective Date of Policy _____

Member ID Number _____ Group/Account Number _____

I hereby authorize Allergy & Asthma Care, P.A., and its physicians to treat me/my child and to release any and all information to my insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. I also authorize release of information to my other physicians. These authorizations remain in effect from the date of signing until revoked in writing. I hereby assign to Allergy & Asthma Care, P.A. all money to which I am entitled for medical expense relative to services provided but not to exceed my indebtedness. I understand I am financially responsible to Allergy & Asthma Care, P.A. and its physicians for charges not covered by this assignment.

_____ PRINT Parent/Guardian's Name

_____ PRINT Patient's Name

_____ Parent/Guardian Signature

_____ Patient's Signature

_____ /_____ /_____ Date

_____/_____/_____ Date

H. TERRY LEVINE, M.D., FACP, FAAAAI, FACAAI
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ALLERGY & ASTHMA CARE, P.A.
ALLERGY, ASTHMA AND RELATED DISEASES
www.allergycarekc.com

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FINANCIAL AGREEMENT

- All contracted insurance are billed directly to your insurance company as a courtesy of Allergy and Asthma Care, P.A. Any remaining balances for non-covered benefits, deductibles, copays, and co-insurances are your responsibility. We **require** a copy of a valid credit or debit card to be kept on file. **You will receive one paper statement**; in addition, you will receive an EOB (explanation of benefits) from your insurance company explaining the costs incurred and monies due to our facility. **Your credit or debit card will be charged 30 days after the date of your statement** to give you the opportunity to pay balance due by another method. _____ (please initial)

- It may take up to three months or longer for your insurance to process your claim. Therefore, the charge to your credit/debit card may be delayed. We do not charge your card until your insurance company has processed your claim.

- We accept cash, check, Visa, MasterCard, Discover, American Express, or Money Order. Additionally, you may pay through paymydoctor.com, Instamed.com, or CareCredit.

- All accounts that become past due 45 days after your insurance pays, we reserve the right to send your account to a collection agency if the balance is not paid in full within 60 days.

- A copy of this form will be available at your request.

- Thank you for choosing us as your provider.

I hereby acknowledge that I have read, understand and agree with the policies set forth by Allergy and Asthma Care, P.A., and any change made by me will be made only in writing. I give my authorization for the charge of my valid credit/debit card.

Printed Patient Name _____ Signature _____

Parent/Guardian Signature _____ Date _____

Reviewed by _____