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 _____/_____/_____ Sex: ☐ 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

CELINA C. BERNABE, D.O., FAAAAI, FACAAI
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Allergy & Asthma Care

www.allergycarekc.com

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10787 NALL AVE. • SUITE 200 • OVERLAND PARK, KANSAS 66211 • (913) 491-3300 • FAX (913) 491-0904

FINANCIAL POLICY

- 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. If you choose to put an HSA or Benefits Card on file, a valid credit or debit card is still required to be kept on file as secondary.

- **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 at least 30 days after the date of your statement to give you the opportunity to pay balance due by another method. It may take up to 3 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. 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.

- We have adopted a **NO SHOW** policy that requires at least a 24-hour cancellation notice. Failure to give us a 24-hour notice will result in a $45 charge per patient.

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

  A copy of this form will be available at your request. Thank you for choosing us as your provider.

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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 _____