ALLERGY & ASTHMA CARE CENTER, P.A.
REGISTRATION INFORMATION
(Please Print)

Date: _____ Home Phone: _____

PATIENT: _____
(Last) (First) (Middle Initial)

Street Address: _____
City: _____ State: _____ Zip: _____
Birth Date: _____ SS #: _____ Sex: ( ) M ( ) F Age: _____
Patient Employed By (Name of the Company): _____
Business Address: _____
Occupation: _____ Business Phone: _____

Spouse's Name (Parent's Name, if minor): _____
Employed By: _____
SS#: _____ Business Phone: _____

Who is responsible for this account? _____ Relationship to Patient: _____
Home Address: _____
Employed By: _____ Home Phone: _____
SS#: _____ Business Phone: _____

Do you have Medical Insurance? ( ) Yes ( ) No If yes,
Name of Primary Insurance Company: _____
Group #: _____ Subscriber #: _____
Deductible: $_____ Co-Pay: $_____
Name of Secondary Insurance Company: _____
Group #: _____ Subscriber #: _____
Deductible: $_____ Co-Pay: $_____

Purpose of Visit: _____
Your Primary Doctor's Name: _____ Phone Number: _____
Your Drugstore's Name: _____ Phone Number: _____
In case of emergency, who should be notified? _____ Phone Number: _____
How did you learn of our practice? _____

Financial: I prefer to: ( ) Pay my balance in full at the time of service
( ) Make payment arrangements prior to services rendered

I acknowledge and understand that I am financially responsible for any balance owed on my account. I understand and acknowledge that collecting monies from insurance company (ies) is my responsibility. I understand that if the bills for services rendered are not paid within 45 days of the date of service, finance charges of 1.5 % per month will be added to the account, in addition to any collection charges and court fees.

Signed (Responsible Party): _____ Date: _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefit submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or services tot be rendered without obtaining my signature on each and every claim submitted on behalf of myself and/or my dependents and I will be bound by this signature as though the undersigned had personally signed the particular claim form.

Signed (Responsible Party): _____ Date: _____

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to Help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As out patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing

PARESHA S. SHAH, MD
ALLERGY & ASTHMA CARE CENTER, PA

Certified by American Board of Allergy & Immunology, Member ACAI, AA

ACKNOWLEDGEMENT

I, _____ (patient/guardian), acknowledge that I have received a copy of Allergy & Asthma Care Center, PA Notice Regarding Privacy of Personal Health Information (PHI).

_____
Patients Name

_____
Patients Date of Birth

_____
Signature of Patient/Guardian

Date: _____

PARESHA S. SHAH, MD
ALLERGY & ASTHMA CARE CENTER, PA
860 Route 168, Suite 206
Turnersville, NJ 08012

MEDICAL INFORMATION RELEASE FORM

Permission to release medical information to spouse or family member: Yes ( ) No ( )

If yes, please list names of individuals:

_____

_____

_____

Permission to leave message on answering machine at home in regards to any and all test results: Yes ( ) No ( )

Patients Name: _____

DOB: _____

Parents name if minor: _____

Date: _____

******I AM AWARE I MUST GIVE 24 HOUR NOTICE FOR ANY OFFICE VISIT CANCELLATIONS OR I WILL BE CHARGED A $ 25.00 FEE. I AM ALSO AWARE THAT IF THE OFFICE IS CLOSED, THAT I AM ABLE TO LEAVE A MESSAGE ON THE ANSWERING MACHINE AT ANY TIME.**

Signature: _____ Date: _____

PARESHA S. SHAH, MD
ALLERGY & ASTHMA CARE CENTER, PA
860 Route 168, Suite 206
Turnersville, NJ 08012

PATIENTS 18 YEARS OF AGE AND OLDER/ADVANCED DIRECTIVE

Do you have an Advanced Directive/ Living Will?

Yes ( ) No ( )

CULTURAL/LINGUISTIC BARRIERS TO CARE

Do you have any of the following? If so. Please circle

Poor Vision Poor Hearing

Language Barrier Religious/Cultural Barriers

None of the Above

PATIENTS 12 YEARS OF AGE AND OLDER

Have you ever, or are you currently using any of the following?
Please check which applies:

Smoking never___past___present___occasionally___

Alcohol never___past___present___occasionally

Drugs (Illicit) never___past___present___occasionally

Patients Name_____DOB _____

Today Date: _____