

**Academy
Allergy
Asthma &
Sinus, PC**

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www.academyallergy.com

Welcome to Academy Allergy Asthma & Sinus!

Thank you for choosing Academy Allergy Asthma and Sinus, PC. We look forward to providing you with the best medical care for your allergy, asthma and immunology problems. You have put your trust in us to make the best diagnoses and treatment plan for you. In order to do so, we need your help in providing essential information through our registration forms. If you have any questions about our forms or your appointment please call the office. We encourage you to visit our website for more information about our practice and providers.

www.academyallergy.com

What to bring to your appointment:

1. Completed Forms in this Envelope:

- Financial Policy
- Patient Registration
- List of medications

2. Insurance Card

3. X-Rays or Laboratory Reports

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please arrive at least **15 minutes early** to allow our staff to complete your registration. If you need to cancel your appointment please give us 24 hours notice so we can offer your appointment time to someone on our waiting list. We also ask that you not wear any perfume or cologne in our office.

Allergy Testing Procedures:

Based on your symptoms, we may find it necessary to perform tests such as allergy skin testing. Skin testing is performed by applying allergens to the skin and lightly pricking. The results may be raised, red, itchy spots, which will appear within 15 to 20 minutes after being pricked. This reaction is similar to a mosquito bite and usually disappears within several days after testing. Reactions can indicate which allergens may be causing your symptoms.

In preparation for your exam, please do not apply any lotions to your arms the day of your appointment or take any prescription or over-the-counter cold or sinus medications or antihistamines for five days.

ACADEMY ALLERGY ASTHMA & SINUS, P.C.

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PATIENT INFORMATION (Please be sure every space is filled out. If it does not pertain to you, please put N/A.)

Form with fields for Patient's Legal Name, Nick Name, Insured's Name, Home Address, City, State & Zip, Date of Birth, Social Security #, Home Phone #, Work Phone #, Cell #, Marital Status, Sex, Patient's Employer, Guarantor's Employer, Employer's Address, Primary Care Physician Name, Office Phone #, Referring Physician Name, Office Phone #, Emergency Contact, Relationship to Patient, Home Phone#, Work Phone #, E-mail Address, Consent to Use E-mail Address.

1. I hereby consent to the physician and other persons acting under his direction and supervision to administer examination, treatments and other procedures as are deemed necessary.

2. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In addition, I hereby designate Academy Allergy Asthma & Sinus, PC and its employees and agents as my representative to file grievances and to represent me in accordance with the Indiana Code, Title 27, Chapters 8 & 13. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand this authorization will remain in effect until revoked in writing. I hereby agree to pay Academy Allergy Asthma & Sinus, PC the charges for all medical services rendered. In the event that I fail to pay the fees as agreed, I understand I will be responsible for all attorney fees, court costs and collection fees that may result from my failure to pay, to which may be added prejudgment and/or post-judgment interest at the current legal rate.

3. I acknowledge receipt of this facility's Notice of Privacy Practices. (Available anytime on-line or in our offices)

Patient Signature _____ Date _____
(Parent or Legal Guardian if Patient is under 18 years old)

Consent for Treatment of a Minor

I, the undersigned, am the legal guardian of _____ a minor I do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of a provider of Academy Allergy Asthma & Sinus P.C. licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned provider in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signature _____ Date _____

ACADEMY ALLERGY ASTHMA & SINUS, P.C.
(317) 621-2455 www.academyallergy.com

David L. Patterson, MD

Tracy A. Donahue, FNP

Name: _____

Date of Birth: _____

FINANCIAL/OFFICE POLICIES

Thank you for choosing us as your health care provider. We appreciate your confidence and trust. Payment for your care is considered part of your treatment program. If you have any questions regarding our financial policy, please call our office manager during business office hours. The following is a statement of our policies that we require you to **read, initial and sign prior to any treatment.**

_____ All patients must complete our patient and insurance information sheets prior to seeing the physician. If these forms are not completed, you may be asked to reschedule your appointment.

_____ If you do not have insurance, we expect payment in full at the time of service.

_____ We are happy to file your insurance claim directly with your insurance company. Our insurance claims are computerized to insure proper filing. We will prepare and file insurance claims for the services you receive. **However, please keep in mind that it is your insurance contract, and we look to you for payment, not your insurance company.** All balances are due within 30 days of the statement date. A \$10.00 administrative fee will be charged each month on past due balances.

_____ **We require all co-payments and deductibles to be made at the time of service, without exception. You are obligated and responsible to pay your portion.**

_____ **Statement of Managed Care Responsibilities:** In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care programs. While we are happy to provide this service, it is extremely difficult to keep track of all the individual requirements of each and every plan. Even within the same insurance company, the plans may differ depending on what type of contract your employer has negotiated. **Therefore, if you do not inform us of any pre-authorization requirements in your contract, and we subsequently treat you without the necessary authorization, we will have no choice but to bill you directly for the charges.**

_____ **Lost Prescriptions & Refills:** Prescription refill requests are handled during office hours by phone. Refill requests can take up to 48 hours to process. There will be a \$5.00 charge for lost prescriptions.

_____ **Medicare:** Our office is enrolled in the Medicare program, which means we have a signed contract with Medicare to accept assignment of Medicare benefits for our services. We will complete and submit your Medicare insurance form for you. Medicare will pay its share of the bill directly to us. You will be responsible for annual deductibles and co-payments.

_____ **Appointments and Cancellations:** Promptness is appreciated for all appointments. All patients including those receiving allergy shots are required to check in. We require 24 hours notice if you need to cancel your appointment. (We have voice mail available after hours.) This will allow us time to offer your appointment to another patient. We often have a waiting list of patients who need to be seen. In order for our providers to deliver quality care, you will need to arrive at your scheduled time. Therefore, if you arrive fifteen or more minutes late for your appointment, you may be asked to reschedule. Failure to provide advance notice for cancelling an appointment will have the following charge schedule applied. First occurrence: missed appointment warning letter; Second occurrence: full scheduled service charge. If three appointments are missed with no advance notice, our professional relationship with you will be terminated and you will be asked to seek treatment from another health care provider. In the event of severe weather, please phone the office for delay or closing information.

_____ **Medical Records Copying & Form Completion:** Requests for copies of patient medical records will be subject to a fee as authorized by Indiana Law. If records are to be mailed, there will be an additional postage charge.

There is a \$10.00 charge to complete forms for school and a \$25.00 to complete forms for insurance companies or FMLA (Family Medical Leave Act) forms.

_____ **Treatment of Minors:** The parent or legal guardian who brings a minor to the office for treatment shall be responsible for all medical bills incurred at that time.

_____ **Agreement to Financial and Office Policies:** I have read and thoroughly understand the financial policy stated above, and I agree to accept financial responsibility as described. I hereby agree to pay **ACADEMY ALLERGY, ASTHMA & SINUS, P.C.** the charges for all medical services rendered. In case of default in payment of my fees, I will be responsible for all attorney fees, court costs and collection fees to which may be added pre-judgment and/or post-judgment with interest at current legal rate. If I am agreeing and signing on behalf of a minor patient, I affirm that I have the legal right to consent and agree on behalf of that minor.

Signature: _____
(Parent or Legal Guardian if Patient is under 18 years old)

Date: _____