ALLERGY & ASTHMA ASSOCIATES – SOUTH

40 Tremont Street
Duxbury, MA 02332
(781) 934-6200

33 Cohasset Avenue
Buzzards Bay, MA 02532
(508) 759-7555

PLEASE PRINT

DATE OF APPOINTMENT: _____/_____/_____

PATIENT NAME_____NICKNAME:_____
Last First Middle Initial

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP_____

HOME PHONE (_____) _____ WORK PHONE (_____) _____EXT_____ CELL PHONE (_____)_____

EMAIL ADDRESS FOR APPOINTMENT REMINDERS:_____

CIRCLE ONE: MALE FEMALE MARITAL STATUS: MINOR MARRIED SINGLE WIDOWED DIVORCED

DATE OF BIRTH:_____/_____/_____SSN _____ SPOUSE OR PARENT'S NAME _____

PATIENT'S OCCUPATION _____ EMPLOYER/SCHOOL_____

PATIENT'S PRIMARY CARE PHYSICIAN _____
Last First

PHYSICIAN'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHARMACY _____ CITY _____ PHONE NUMBER (_____)_____

EMERGENCY CONTACT_____ PHONE (_____)_____ RELATIONSHIP_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____

CERTIFICATE OR ID# _____*NAME OF INSURED:_____

INSURED'S PHONE (_____)_____ SSN _____ RELATIONSHIP TO PATIENT _____

MAILING ADDRESS OF INSURED_____ CITY_____STATE_____ZIP_____

D.O.B. OF INSURED _____/_____/_____ INSURED'S OCCUPATION _____ EMPLOYER _____

IF YOU HAVE OTHER INSURANCE, PLEASE COMPLETE THE FOLLOWING:

SECONDARY INSURANCE COMPANY_____

CERTIFICATE OR ID#_____*NAME OF INSURED:_____

INSURED'S PHONE (_____)_____ SSN _____ RELATIONSHIP TO PATIENT_____

D.O.B. OF INSURED_____/_____/_____ INSURED'S OCCUPATION_____ EMPLOYER_____

BILLING INFORMATION

**** IF PATIENT IS A MINOR, PERSON RESPONSIBLE FOR ANY BILLS: *****

NAME _____
Last First Middle Initial

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____ SSN _____

OCCUPATION _____ EMPLOYER _____

HOME PHONE (_____)_____ WORK PHONE (_____)_____

PATIENT NAME:_____ **DATE OF BIRTH:** _____/_____/_____

EXTENDED AUTHORIZATION AND CONSENT

BILLING OFFICE:

ALLERGY & ASTHMA ASSOCIATES – SOUTH
33 COHASSET AVENUE
BUZZARDS BAY, MA 02532
TEL: 508-759-7555
NPI #1447259536

I request that payments of medical benefits be made directly to the above named provider on any unpaid bills for services rendered. I further authorize the release of any medical information necessary to process this or related claims. I understand that co-payments, deductibles, co-insurance and fees for service not covered by my insurance are my responsibility. If my insurance company denies payment or I have no insurance, I understand that I am financially responsible for all charges and if I have provided any incorrect information, my insurance company will not cover services provided. I certify that upon any changes I will notify Allergy Asthma-South immediately with the new information. Failure to do so, could result in me being financially responsible. I permit a copy of this authorization to be used in place of the original.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

PATIENT OR GUARDIAN PRINTED NAME _____

REFERRAL AUTHORIZATION

Please sign this if your insurance requires a referral from a primary care physician.

We are always happy to submit a claim to insurances requiring referrals for services rendered. However, in most cases, these insurances do not cover any service which is not approved, arranged or provided by your primary care physician. (Please consult your member handbook for a list of services which require a referral from your primary care physician.)

I understand that I am financially responsible for obtaining and keeping current, necessary referrals. I also understand that if I receive specialty services without the consent of my primary care physician, I will assume financial responsibility for such services. I permit a copy of this authorization to be used in place of the original.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

PATIENT OR GUARDIAN PRINTED NAME _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Occasionally, one of our physicians requires a copy of **past** X-rays, MRI/CT scans, ER reports, etc., from either your primary care physician or hospital where testing/treatment was done. Your signature below authorizes the release of such medical records, including any laboratory reports, diagnostic testing, X-rays, etc., to Allergy & Asthma – South. **At no time** will this information be requested without your prior knowledge.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

PATIENT OR GUARDIAN PRINTED NAME _____

7/1/17