Allergy & Asthma
Physicians of Commerce Township

Pulin P. Patel, D.O., F.A.C.A.A.I.

Board Certified in Pediatric & Adult
Allergy, Asthma & Immunology

2615 Union Lake Road
Commerce Township, MI 48382-3557
p. 248.560.7555
f. 248.716.9120

1030 Harrington Street, Suite #301
Mount Clemens, MI 48043-2967
p. 586.961.6060
f. 586.961.6061

Dear New Patient:

Welcome to our practice. We are very pleased that you have selected us for your medical care. Enclosed are forms for you to fill out **in advance** of your appointment to assist our office staff and Dr. Patel in making sure that we have all the information necessary to provide you with quality care and treatment.

Please fill out all the forms completely in black ink. If you have any questions or problems filling out the forms, do not hesitate to call so that we may assist you. **When you have completed your forms, please return them to our office prior to your appointment or bring them with you to your first appointment.**

If you have been treated by a physician or hospital for the reason you are visiting us (example: allergies, asthma, hives, anaphylaxis), then you may want to request copies of pertinent medical records in advance of your appointment. You may either have them give the records to you directly, or they can mail them to us.

If you belong to an HMO such as Blue Care Network, **it is your responsibility to make sure that you have a valid referral from your primary care physician's office**. If you do not have a valid referral, you will be required to pay for your office visit at our standard rate at the time of your office visit.

Once again, welcome to our practice. We look forward to providing you with quality care.

Cordially,

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A. Personal Information

Patient's Name _____ (Last / First / Middle / Maiden) Date of visit _____

Home Address _____ (Street / Apartment/Suite) Date of Birth _____ Age _____

_____ (City / State / Zip) Marital ☐Single ☐Married ☐Widow/er ☐Divorced Sex ☐M ☐F

Employer or School _____ (Name / Occupation/Grade) E-mail _____

Address _____ (Street / Apartment/Suite) Home _____

_____ (City / State / Zip) Cell Phone _____

SS# Work Phone

B. Consultation Information (Please furnish us with their name & address)

Consult requested by (specify) ☐Primary Doctor ☐Other
☐Family/Friend ☐Ins. Co. ☐Self ☐I am requesting a 2nd opinion

Name _____

Addres _____ (Street / Apartment/Suite)

_____ (City / State / Zip)

Phone Fax

Primary Doctor Name _____ (Last / First)

Addres _____ (Street / Apartment/Suite)

_____ (City / State / Zip Code)

Phone # fax

Pharmacy Name & #

C. Responsible Party (Primary Insurance Holder or Parents if patient is under 21)

Mothers Name or Legal Female Guardian or Spouse _____ (Last / First / Middle) Home _____

Work/Cell Phone _____

Address _____ (Street / Apartment/Suite) Date of Birth _____

Occupation _____

_____ (City / State / Zip)

Employer and Address SS# _____

Name / Street / Suite / City / State / Zip

Fathers Name or Legal male Guardian or Spouse _____ (Last / First / Middle) Home _____

Work/Cell Phone _____

Address _____ (Street / Apartment/Suite) Date of Birth _____

Occupation _____

_____ (City / State / Zip)

Employer and Address SS# _____

Name / Street / Suite / City / State / Zip

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ASSIGNMENT OF BENEFITS

I hereby authorize payment to any physician of Allergy & Asthma Physicians of Commerce Township, P.C. who has treated my dependents or me for medical services rendered. I understand that I am financially responsible for all services not covered by my insurance company. I also understand that if I do not give a minimum of 48 hours' notice for cancellation of allergy skin testing appointments, I will be billed a $50 cancellation fee that is not covered by my insurance. Failure to cancel office visit appointments at least 24 hours prior to appointment will result in a $25 charge that is not covered by my insurance.

Signature: _____ **Date:** _____

Release of Information: I hereby authorize the physicians of Allergy & Asthma Physicians of Commerce Township, P.C. to release my information required to process any claims for my dependents or me.

Signature: _____ **Date:** _____

We make every effort to contact your insurance company and verify your benefits. However, verification of insurance benefits is not a guarantee of payment until claims are submitted and the insurance company reviews all records. If your insurance company denies payment or services are not covered, you will become financially responsible for services. Please be aware that if you participate in an HMO and need a referral for this visit or any other services,

IT IS YOUR RESPONSIBILITY TO MAKE SURE WE HAVE THE REFERRAL IN OUR OFFICE BEFORE THE VISIT.

The office cannot be responsible for obtaining referrals.

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PATIENT CONSENT FORM FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION
HIPPA CONSENT FORM

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your health information in our possession (collectively "Protected Health Information").

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

For a more complete description of how this office may use or disclose your Protected Health Information, please review the *Notice of Privacy Practices* that this office has prepared. Please also see our *Notice of Privacy Practices* for a more detailed discussion of the meanings of "treatment", "payment" and "health care operations". A copy of our *Notice of Privacy Practices* will be made available to you by contacting Pulin P. Patel, D.O.

You have the right to review our *Notice of Privacy Practices* prior to signing this consent. Please be advised that the *Notice of Privacy Practices* may be revised by this office from time to time. Any such revised *Notice of Privacy Practices* will be made available to you by contacting Pulin P. Patel, D.O.

You should also review carefully the *Notice of Privacy Practices* because it contains a list of rights that are available to you with respect to this office's use and disclosure of your Protected Health Information. These rights include your right to request restrictions on our use and disclosure of your Protected Health Information.

You have the right to revoke this consent at any time. If you wish to revoke this consent, you must do so in writing.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By signing below, you acknowledge that you have read and understand this consent and this office's *Notice of Privacy Practices*. You further acknowledge that you have received (if one was requested) a copy of this office's *Notice of Privacy Practices* to take with you.

Patient name: _____ Date: _____

Signature: _____

Relationship to patient: _____

Original November 2012

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MEDICAL INSURANCE COVERAGE INFORMATION

THIS IS VERY IMPORTANT. ***WE DO NOT KNOW YOUR COVERAGE.*** IT IS YOUR RESPONSIBILITY TO VERIFY WHETHER OR NOT ALLERGY SERVICES ARE COVERED BY YOUR INSURANCE. PLEASE CALL YOUR INSURANCE AND ASK, SPECIFICALLY, IF THE FOLLOWING PROCEDURE CODES WILL BE COVERED.

When you are determining your benefits please remember participation in an insurance plan by a physician **DOES NOT** indicate any or all services will be covered.

Annual Individual Deductible $_____; Annual Family Deductible $_____; Have these been met? ☐YES ☐NO

1.	New patient office visit: 99205	Coverage _____, Deductible $_____, Copay $_____
2.	Diagnosis for Asthma – 493.9; Allergies – 477.9; Hives – 708.9	Coverage _____, Deductible $_____, Copay $_____
3.	Allergy skin testing (if needed): 95004 and/or 95024	Coverage _____, Deductible $_____, Copay $_____
4.	Lung function test (if needed): 94060 and 94375	Coverage _____, Deductible $_____, Copay $_____
5.	Follow-up office visit: 99213	Coverage _____, Deductible $_____, Copay $_____
6.	Allergy injections (if needed): 95117	Coverage _____, Deductible $_____, Copay $_____
7.	Allergy serum (if needed): 95165*	Coverage _____, Deductible $_____, Copay $_____

- If allergy serum is not covered by your regular medical plan, you may inquire to find out if it is covered by your prescription drug plan.

Our office would like to cooperate with you in the collection of insurance benefits for medical services. As a service to our patients, our office will bill your insurance company. However, in order to avoid misunderstandings, please read the following statements very carefully.

A. The insurance company has an obligation to the patient, **not** to the doctor.
B. The patient alone is obligated to the doctor for payment of services.
C. The doctor **cannot** state what services an insurance company covers or the amount of coverage. The patient must determine coverage from their insurance company, benefits administrator or agent. Call your insurance company if you have any questions about your coverage. The patient alone is responsible for determining coverage.
D. Most insurance companies send payment from 14 days up to 60 days after the visit. This office will extend credit to patients for up to 90 days from the date services are rendered while waiting for the insurance company to pay. ****IMPORTANT**:** If the insurance company does not pay the bill within 90 days, the amount due automatically becomes the responsibility of the patient. The patient may seek reimbursement directly from the insurance company after 90 days, if he or she so desires.

As stated above, our office will submit the original bill to your insurance company. This in no way relieves the patient of their obligation to the doctor nor does it imply that the fees for services are thereby settled. Payment of the balance is required at the time of service unless prior individual arrangements are made. Your cooperation in this matter will benefit all concerned.

For patients with **Master Medical (a product of Blue Cross Blue Shield)** payment is required in full. You will be required to pay consultation, allergy testing, allergy immunotherapy and allergy serum fees up front at the time of service. We bill electronically and usually it only takes one to two (1-2) weeks to receive your payment from your insurance company. **Should further questions arise, please call the office.**

For patients with **managed care, HMO, POS** or any other insurance that requires a referral, the patient is responsible for making sure that he or she has a **VALID REFERRAL** before the date of the visit. If a referral is required by your insurance, and the patient arrives for a visit without a valid referral (even if the patient forgot to bring it from home or forgot to pick it up from the referring physician's office), the patient will be required to pay at time of service.

For patients on **Allergen Immunotherapy (allergy shots):** Your insurance company will be billed as soon as new allergy serum is made. Since allergy serum is made individually for a specific patient, it cannot be used for any other patient.

In divorce cases, our office policy is that whomever brings the child in to see the doctor is responsible for the charges on that day. Reimbursement, if any, is a matter between the mother and the father.

I have read the "Medical Insurance Coverage Information" completely and agree to it.

Signature _____ **Date** _____

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