Allergy and Asthma Care of Florida

G. EDWARD STEWART II, M.D.* THOMAS L. JOHNSON II, M.D.*
BEAU J. CARUTHERS, ARNP

* Diplomate of
The American Board of Allergy and Immunology

Welcome To Our Practice!

We appreciate the confidence you have placed in us. Our staff of well-trained professionals will work together as a team to provide you with the highest quality treatment.

Allergists and clinical immunologists are trained medical specialists who have completed a lengthy training process of at least nine years of intense study. After completing medical school and three years of training in internal medicine or pediatrics, we completed specialized allergy and immunology training programs called fellowships. We have successfully passed the certifying board examination of the American Board of Allergy and Immunology.

Enclosed are several forms which we ask you to complete prior to coming to your appointment. The information you provide is essential to us for your medical evaluation and to our office staff for establishing your medical records and billing your insurance. Please bring these forms with you for your initial visit, along with any insurance cards so that we may copy them for your folder.

To ensure that you have coverage for allergy testing, please call the phone number listed on your insurance card prior to coming to your appointment. If we can be of assistance in providing information to help you do this, let us know. <u>If your insurance company requires your primary care physician to provide us with an authorization for this office visit, please contact your doctor and have them fax us the necessary information</u>. Our fax number is 352-622-2391. If we are not a provider for your insurance company, we will file your first office visit as a courtesy to you. We will be happy to provide you with a form for you to file your insurance for follow-up visits.

If you have any questions or concerns, please feel free to call our office and we will be glad to assist you in any way possible. We will continually strive to provide you with the finest health care available.

Sincerely,

G. Edward Stewart II, MD
Thomas L. Johnson II, MD
& Staff

1740 S.E. 18th Street, Suite 1002 Ocala, Florida 34471
1501 US Hwy 441 N., Suite 1406 The Villages, Florida 32159
Telephone (352) 622-1126 Lake County Toll Free 753-1422 Toll Free 1-866-904-2223 Fax (352) 622-2391

Formulary Medication Requests

We are aware that most insurance plans have formularies. These formularies dictate what medications or at what level the medications will be covered by your plan. If you would like us to help you receive better coverage for your medications, it is important that you bring your formulary with you every office visit.

Please understand that our providers will recommend the medications that are best suited for your condition. Just because the medication is on your formulary, it doesn't mean that it is the best one for your condition. *Please list your medications below*

Patient Name: ______________________________ Date of Birth: __________

Medication Name:	Allergies to Medications (name/reaction):

Immunization Name:	Date Immunization given:
Influenza	
Pnemonia	
Shingles	

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Allergy and Asthma Care of Florida for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Allergy and Asthma Care of Florida. I understand that diagnosis or treatment of me by Allergy and Asthma Care of Florida may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Allergy and Asthma Care of Florida is not required to agree to the restrictions that I may request. However, if Allergy and Asthma Care of Florida agrees to a restriction that I request, the restriction is binding on Allergy and Asthma Care of Florida. I have the right to revoke this consent, in writing, at any time, except to the extent that Allergy and Asthma Care of Florida has taken action is reliance on this consent. My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Allergy and Asthma Care of Florida's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Allergy and Asthma Care of Florida. The Notice of Privacy Practices is provided at the front desk or in the waiting room. This Notice of Privacy Practices also describes my rights and Allergy and Asthma Care of Florida's duties with respect to my protected health information.

Allergy and Asthma Care of Florida reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain access to the revised notice by contacting Allergy and Asthma Care of Florida's Privacy Officer.

Patient's Name ________________________________

Patient's Date-of-Birth ________________________________

Signature of Patient or Personal Representative________________________________

Printed name ________________________________

Date ________________________________

Description of Personal Representative's Authority

____

Allergy and Asthma Care of Florida
1740 S.E. 18th Street, Suite 1002
Ocala, Florida 34471
(352) 622-1126

PATIENT RECORD OF DISCLOSURES

HIPAA Privacy Regulations gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as, sending correspondence to the individual's office instead.

I wish to be contacted in the following manner (check all that apply):
Home telephone

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Work telephone and cellular telephone

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

Written communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my workplace
- ☐ O.K. to fax to this number: ______________________________

Waiting room communications

- ☐ O.K. to call me by my formal name (Mr., Mrs., Ms., or Miss)
- ☐ I would like to be called by ______________________________

Personal contacts – O.K. to release Protected Health Information to the following person(s).

Name: ______________________________ Relationship: ____________________________

Name: ______________________________ Relationship: ____________________________

I understand that it is my responsibility to change this information should my circumstances change. I will notify Allergy and Asthma Care of Florida of any changes.

Patient's name ____

______________________________________ ____________________________
Patient signature/personal representative Date

______________________________________ ____________________________
Printed name Patient's date of birth

Allergy & Asthma Care of Florida, Inc.

Financial Policy and Insurance Billing Information

We are dedicated to providing you with the best possible care and service. Your understanding of our financial policies is an essential element of your care and treatment. Our policy is that unless other arrangements have been made in advance, **full payment is due at the time of service**. This enables us to avoid the cost of sending monthly statements, thus allowing us to keep our fees down. For your convenience we accept Debit cards and most major credit cards.

Insurance Plans:

We have made arrangements to accept a wide variety of medical plans. We will be filing claims according to our contract with each company. We will bill those plans with which we have an agreement and will collect any required co-payment, coinsurance and deductible from you at the time of service. In the event your health plan determines a service to be "not covered", you may be responsible for the complete charge. In the event that we bill you, your payment will be due upon the receipt of that statement. For your information, we recommend that you contact your insurance carrier to determine benefits for your care in our office. We may contact you once we verify your coverage to help you understand your responsibility.

Medicare:

Medicare doesn't always cover all procedures and testing that we perform in our office. If we need to perform a test that Medicare may not cover, a staff member will have you sign an Advanced Beneficiary Notice explaining this prior to the testing. If Medicare does not cover the test, you will be responsible for the charge. Our billing staff may appeal for coverage of the service upon request. Please feel free to contact our billing office for assistance.

Authorizations/Referrals:

Please understand that it is your responsibility to make sure each visit that your authorizations/referrals are current so that each visit is covered under your plan. Failure to do so could make the visit 100% your responsibility.

Collections:

Delinquent accounts may be turned over to our collections agency. If this occurs, the account balance, which may also include a collections fee, must be **paid in full** prior to another appointment being scheduled. Dismissal from the practice may also occur.

Missed Appointment Fees/Insufficient Funds:

Please be courteous and contact us within 24 hours to reschedule or cancel your appointment. We reserve the right to charge you $25-50 for missing your appointment. If you have a returned check, there will be a fee of $10.00. Fees of this nature must be paid in full prior to more services being rendered.

Minor Patients:

Minor patients (under the age of 18) must be accompanied by a legal guardian in order to receive care. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment at time of service. Both parents/legal guardian(s) are responsible for payment of services rendered to the patient.

I have read and understand the above financial policy of Allergy & Asthma Care of Florida. I also agree to the terms presented.

______________________________	______________________________
Printed Name of Patient/Guardian	Patient's Date-of-Birth
______________________________	______________________________
Signature of Patient/Guardian	Date

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Ocala, FL 34471

1501 US Hwy 441 N, Ste. 1406
The Villages, FL 32159

PATIENT INFORMATION REGISTRATION FORM

Your information is protected by HIPAA. Please see our Notice of Privacy Practices.

PERSONAL INFORMATION

Patient's Full Name: ____________________ DOB: __/__/__ Age: ______ Sex: ☐Male ☐Female

Address: ____________________ City: ____________ State: ______ Zip: ______

Home Phone #: ____________ Cell Phone #: ____________ ☐Caucasion ☐African American

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Hispanic ☐Indian ☐Other: ______

Social Security #: ____________ Driver's License #: ____________

* I hereby give consent for treatment.
* I hereby authorize any physician, hospital or medical facility to release any information concerning my medical history and treatment to Allergy & Asthma Care of Florida
* I hereby authorize my insurer(s) to pay benefits directly to Allergy & Asthma Care of Florida.
* I acknowledge that I am personally responsible for all charges and balances remaining after insurance benefits have been paid.
* I authorize the release of all medical records, **including/excluding (CIRCLE ONE)** HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes, to the referring and family physicians and to my insurance company, if applicable.
* I allow faxed transmittal of my medical records, if necessary.

Signature of Patient/Parent/Guardian: ____________________ Date: ____________

Patient's Employer: ____________________ Work Phone #: ____________

Address: ____________________ City: ____________ State: ______ Zip: ______

Occupation: ____________________ If student: ☐Full-time ☐Part-time

Spouse (or parent): ____________________ Social Security #: ____________

Address (if different from patient): ____________ City: ____________ State: ______ Zip: ______

Spouse's (or parent's) Employer: ____________________ Work Phone #: ____________

Address: ____________________ City: ____________ State: ______ Zip: ______

Occupation: ____________ Driver's License #: ____________

In case of emergency, contact (other than spouse): ____________________

Address: ____________________ City: ____________ State: ______ Zip: ______

Relationship: ____________________ Phone #: ____________

Family Physician: ____________________ Phone #: ____________

Referring Physician: ____________________ Phone #: ____________

Email Address: ____________________

Pharmacy name and phone number: ____________________

INSURANCE INFORMATION

We ask all patients to present their insurance cards to the receptionist. All co-payments and deductibles are to be paid at the time of service.

Primary Coverage, Name of Carrier: ____________________

ID#: ____________________

Policy or Group #: ____________________

Secondary Coverage, Name of Carrier: ____________________

ID#: ____________________

Policy or Group #: ____________________

Insured Party's Name: ____________________ DOB: __/__/__ Social Security #: ____________

Patient's Relationship to Insured: ____________________