Patient Registration Form

Allergy Asthma & Immunology, PC
7945 W Sahara Ave Ste 108
Las Vegas, NV 89117

Patient Information (for the individual being seen)

Last Name	First Name	Middle Name
Street	City, State, Zip	Sex
Date of Birth	Ethnicity	e-Mail
Mobile Phone	Business/Day Phone	Home/Evening Phone
Occupation	If Student, _ Full-time _ Part-time	If Employed, _ Full-time _ Part-time
Employer	Emergency Contact	Phone
_ Single _ Married _ Separated _ Divorced _ Widowed	If not Referred, How Did You Hear about Us?	
Primary Care Physician to Whom Report Should be Sent	Other Physicians to Whom Report Should be Sent	

For the following sections, indicate "SAME" if the patient and financially responsible party are the same individual.

Primary Insurance (for the financially responsible individual)

Last Name	First Name	Middle Name
Street	City, State, Zip	Sex
Date of Birth	Relation to Insured	e-Mail Address
Mobile Phone	Business/Day Phone	Home/Evening Phone
Relation to Insured	Employer	Insurance Company
Insurance Address	City, State, Zip	Toll-Free Phone
Policy ID	Policy Group	Effective Date

Secondary Insurance (leave blank if not applicable)

Last Name	First Name	Middle Name
Street	City, State, Zip	Sex
Date of Birth	Relation to Insured	e-Mail Address
Mobile Phone	Business/Day Phone	Home/Evening Phone
Relation to Insured	Employer	Insurance Company
Insurance Address	City, State, Zip	Toll-Free Phone
Policy ID	Policy Group	Effective Date

Consent to be Treated and for Payment

I consent to medically necessary evaluation and treatment for myself or for a minor for whom I am authorized. This consent covers fully the use or disclosure or both of health information that may specifically or be able reasonably to identify me for the sole purpose of carrying out treatment, payment, and health care operations.

I have listed *all health plans from which I may receive benefit*. If my health plan information changes since the last visit, I am *responsible for notifying of the new coverage*. If this information is not correctly provided, I might not have access to benefits I have contracted with my health plan, including paying the full amount for services.

I hereby authorize payment of medical benefits billed to my insurance to Allergy Asthma & Immunology, PC (the "office"). I hereby accept responsibility for the portion of payment for any services provided to me that is not covered by my health plan. I also accept responsibility for fees that exceed the payment made by my plan, if the office does not participate with my insurance.

The office is usually *required by contract with the health plan to collect this payment at the time of service*. Sometimes this amount is the *best possible estimate*. If this amount is off, a refund/credit or invoice will he handled after the claim is processed and any appeals completed.

I have been informed that the office has prepared a "Notice of Privacy Practices" that fully describes the use and disclosure that can be made of my individually identifiable health information for treatment, payment, and other routine health care operations. I understand that I have the right to review this HIPAA form prior to signing this consent. I may also revoke this consent at any time by notifying the office in writing, but if I revoke the consent such revocation will not affect any actions that the office took before receiving my revocation. The office has reserved the right to alter this privacy policy, and I understand that I can obtain such changes upon request. I have the right to request that the office restrict how my individually identifiable health information is used or disclosed to carry out health care operations. The office is not obligated to agree to such restrictions but once such restrictions are in place must then adhere to such restrictions.

I understand that, while this consent is voluntary, if I refuse to sign this consent the office may decline to treat me.

Thank you for trusting the office with your health needs and for taking the time to complete this registration form.

_____	_____
Signature of Authorized Representative	Date
_____	_____
Name of Patient or Authorized Personal Representative	Description of Authorized Representative's Authority