

COAST ALLERGY/ASTHMA CENTER

RAYMOND E. BRADY, MD

Physician & Surgeon

ACCT # _____

TODAY'S DATE: _____

PATIENT INFORMATION

Patient Name: _____

Last

First

Middle

Physical Address: _____

Mailing Address (if different from above): _____

Home Phone: _____ Work: _____ Cell: _____

Birthdate: _____ Gender: _____ Marital Status: _____ SSN: _____

Spouse/Significant Other: _____ DOB: _____

Address if Different: _____

Primary Care Physician: _____ Referring Physician: _____

FAMILY INFORMATION (IF PATIENT IS A MINOR)

Mother (Guardian Yes___ No___)

Father (Guardian Yes___ No___)

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

(if different from above)

(if different from above)

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

DOB: _____ SSN: _____ DOB: _____ SSN: _____

EMERGENCY CONTACT (someone not living with you):

Name: _____ Phone: _____

Relationship: _____

INSURANCE INFORMATION:

PRIMARY

Insurance: _____

Name of subscriber _____ DOB: _____

ID# _____ Group# = _____

Copay: _____ Employer: _____

SECONDARY

Insurance: _____

Name of subscriber _____ DOB: _____

ID# _____ Group# _____

Copay: _____ Employer: _____

Please continue to other side



**COAST ALLERGY/ASTHMA CENTER
FINANCIAL POLICY NOTIFICATION
RELEASE AND ASSIGNMENT**

The information that I have given is correct to the best of my knowledge and it will be held in strict confidence. I understand that it is my responsibility to inform the office of any changes in this patient's information or medical status. I certify that the patient is covered by the insurance as provided and assign directly to Coast Allergy/Asthma Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Coast Allergy/Asthma Center to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on insurance submissions whether manual or electronic. I agree to pay for charges not covered by insurance when they are billed to me. I understand collection proceedings may be initiated if I do not pay my bills on time and that I may be held responsible for fees incurred in the attempt to collect outstanding debts, including administrative, court, and attorney fees..

PATIENT'S RESPONSIBILITY FOR PAYMENT

I understand that my insurance plan can require a referral from my primary care physician/provider in order to cover the visits to the specialty physician, Dr. Raymond E. Brady. If Coast Allergy/Asthma Center at this time has not received verification that a referral was generated for services, and if my insurance company denies payment, I agree that I will be financially responsible for any and all charges incurred (including lab and x-ray). I understand that lab tests and x-ray procedures will be billed separately from those providers.

Coast Allergy/Asthma Center will submit charges for medical treatment to my primary insurance company and/or Medicare. However, I am responsible for paying any and all medical expenses incurred at the clinic. We routinely try to verify insurance coverage in advance of your appointment. You should contact your insurance company(ies) directly for any coverage questions you may have. If the insurance company denies payment or will only pay a portion of the medical bill, you are responsible for payment of the account balance. Likewise, if you have not met your deductible under a given insurance plan, you will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay.

If I have valid insurance, I understand that a \$75.00 deposit will be requested at the time of my initial visit, unless my insurance requires only a copay. If I do not have insurance, I will be required to make a \$250.00 payment that will be applied to the bill. If paid in full at the time of service, I may be eligible for a cash discount. Any resulting credit/overpayment will be refunded to me. If I participate in an HMO or PPO that requires a co-payment, I must pay the co-payment at the time of appointment.

I hereby assign to Coast Allergy/Asthma Center any and all insurance benefits due me to the fullest extent of my financial obligation. I authorize Coast Allergy/Asthma Center to release to the insurance company any information acquired in the course of my examination and treatment that is allowed by HIPPA regulations.

I understand that Coast Allergy/Asthma Center does not participate in the Oregon Health Plan (OHP) or Washington DSHS. Nor does Coast Allergy/Asthma Center accept any workmen's compensation claims. If I have any pending claims, I agree that payment for any medical care provided will be my responsibility. If I am involved in a motor vehicle or liability accident, I am responsible for paying all medical costs, even if there is a pending lawsuit.

Should it become necessary for Coast Allergy/Asthma Center to utilize the services of an outside collection agency in order to collect the amounts which are due from and owed by me, I will be held liable for any and all collection agency fees, attorney fees, and/or court fees which may add 25% to 50% of the actual charges for services which were rendered to me. Additionally, there will be an administrative fee of \$75 added for collection efforts.

I understand in the case of divorce that the parent who consents to the treatment of a minor child is responsible for payment of services rendered. Coast Allergy/Asthma Center will not be involved with separation or divorce disputes.

I understand that I am personally responsible for all medical expenses incurred at Coast/Allergy/Asthma Center for care and treatment. I agree to pay all medical expenses within 45 days of the date I am notified of the charges or the date expenses were incurred, whichever comes first. I will be assessed a finance fee of 3% per month on the account balance if not paid by this date.

I have read the above Coast Allergy/Asthma Center Financial Policy Notification and understand my financial responsibility with Coast Allergy/Asthma Center. I hereby affix my signature as an acknowledgement of this understanding.

Patient signature (parent/guardian if patient a minor)

Date

Patient printed name