LAKE ALLERGY,
ASTHMA & IMMUNOLOGY

Andrew J. Cooke, MD

PATIENT Today's Date	
Name (First, Initial, Last): Date of Birth: SSN:	
Local Address:	Northern Address:
City: State: Zip:	City: State: Zip:
Marital Status: ❍Married ❍Divorced ❍Widowed ❍Separated ❍Single	
Phone (H) (M) (W) Occupation:	
SPOUSE OR PARENT (If Patient a Minor)	
Name (First, Initial, Last):	
Phone (H) (M) (W) Occupation:	

How did you hear about us? ❍Friend _____________ ❍Doctor _____________ ❍Other _____________

Who is your regular physician? ________________________ Address/Phone: _______________________

Any family member a current patient in this office? No Yes (Please List) __________________________

Preferred Pharmacy: ____

Pharmacy Phone: _______________________Street Address: ____________________ City: ____________

Emergency Contact:__________________________________ Phone: ______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	**SECONDARY INSURANCE COMPANY**
Insurance Company:	Insurance Company:
Policy #	Policy #
Group #	Group #
Policyholder: ❍Self ❍Spouse ❍Parent	Policyholder: ❍Self ❍Spouse ❍Parent
Policyholder Relationship:	Policyholder Relationship:

Policyholder Birthdate:	Policyholder Birthdate:
Policyholder SSN:	Policyholder SSN:

Benefit Assignment and Release of Information:

I hereby authorize the assignment of benefits (payments) directly to Lake Allergy, Asthma & Immunology, PA for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original. This consent is good for the entire time period my children or I are a patient.

_______________________________________ _______________________________________

Signature of Patient Date Signature of Responsible Party (if different) Date

Billing & Cancellation Policies

We will submit charges, at our expense, to your insurance company on your behalf. If it turns out that you owe a portion of the bill or your carrier fails to pay us after 2 attempts to contact hem, we will send you a bill. **If there is no response from you in 30 days**, a $25 late charge will be assessed.
Twenty-four (24) hour cancellation notification is required for appointments. **Failure to notify us or same day cancellations** will result in a $50 no show fee. Please note that insurance companies do not cover these fees, therefore you will be responsible for payment. Initial: ____________

Acknowledgement of Privacy Practices

I, ____________________________, acknowledge that the Notice of Privacy Practices has been made available to me if I so desire a copy. I understand if I decide that I would like a copy at a later date that one will be made available to me.

_______________________________________ _______________________________________

Signature of Patient/Guardian Date Signature of Witness Date

HMO/PPO/POS/Medicare HMO/Medicaid/Tricare HMO patients:

YOU must obtain a **prior authorization number/referral** from your **primary care physician before each visit or injection** at our office. I understand if a referral/number is not issued **my appointment will be rescheduled**. I understand I am responsible for any balance of any unauthorized visits or procedures. Initial: ____________

Permission to Involve Others in Patient Care

I __________________________ am giving Lake Allergy, Asthma & Immunology, PA my permission to involve the below list of people in **my complete medical care**. The person/people I am listing was sharing my medical care. Lake Allergy, Asthma & Immunology, PA can/will discuss (but not limited to) testing, treatment, results of my medical care, history, including referred to physicians/facilities. This permission

includes financial issues involving my care insurance, co-pays, deductibles, personal balance and Bank charges.

Person's Name: __________________________ Relationship: _________________Phone: _________________

Person's Name: __________________________ Relationship: _________________Phone: _________________

Signature of Patient/Guardian Date Signature of Witness Print Name Date