

# Allergy Affiliates, Linden David Ho, M.D., LLC

In order to serve you properly, we will need the following information. **Please fill out completely. Please Print**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ (M) (F)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_ Driver's License: State: \_\_\_\_\_ Number: \_\_\_\_\_

Email Address \_\_\_\_\_ Preferred language \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity  Hispanic  Not Hispanic  I prefer not to answer

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Physician's Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## RESPONSIBLE PARTY IF PATIENT IS A MINOR

Name: \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employed by: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Driver's License #: State: \_\_\_\_\_ Number: \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance Company:** Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ (M) (F)

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Office visit covered? Yes No Referral Needed? Yes No CoPay Amt \_\_\_\_\_

**Secondary Insurance Company:** Name of Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ (M) (F)

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Office visit covered? Yes No Referral needed? Yes No CoPay Amt \_\_\_\_\_

The information above is, to the best of my knowledge, accurate and current. I understand that I am financially responsible for all the charges whether or not paid by insurance. I am responsible for immediately informing the office of any charges in insurance coverage, and I will bear financial responsibility for lack of payment due to inaccurate information. \_\_\_\_\_ ((initials))

If my insurance requires referrals, I understand that I am responsible for obtaining the correct referral forms from my primary care physician. It is also my responsibility to keep them current. I accept financial responsibility for any service not paid due to lack of a referral. \_\_\_\_\_ (initials)

### **CONSENT FOR ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits to Allergy Affiliates, Linden Ho, M.D., LLC for services provided. I authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided for the purpose of evaluating and administering claims of benefits

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **CONSENT TO TREAT**

I, the undersigned as "patient" of being a person legally authorized to consent to services on behalf of the "patient" consent and authorize Allergy Affiliates, Linden Ho, M.D., LLC. to administer any treatment which may be deemed medically necessary for diagnosis and treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **PAYMENT POLICIES**

Copays are due at the time of service. Any copay that has to be billed will incur a \$5.00 billing charge on each outstanding copay, each billing cycle.

Returned checks are subject to a \$20,00 service fee. Checks will not be redeposited.

Signature of responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

### **CONSENT FOR RELEASE OF MEDICAL INFORMATION AND TREATMENT**

Please list the person(s) to whom we may release medical information

\_\_\_\_\_

Please list any person who may bring your child for treatment \_\_\_\_\_

I understand we may revoke this consent in writing at any time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### **NO SHOW AND CANCELLATION FEE**

A 24-hour cancellation notice is required for all appointments. A \$25 fee will be implemented if required notice is not given.

Signature \_\_\_\_\_ Date \_\_\_\_\_