



# ☆ Allergy & Asthma Physicians of Central Kentucky, PSC

166 Pasadena Drive, Suite 150 • Lexington, Kentucky 40503-2938 • (859) 276-1452 • FAX (859) 277-1237

**John S. Hill, M.D. • Neven J. Gardner, M.D. • Tracie L. Overbeck, M.D., PhD. • Douglas B. Tzanetos, M.D.**

**Please fill in all the following information. This will save much time as well as prevent errors in our records. Answer every question as completely as possible.**

Date \_\_\_\_\_

Name of Patient \_\_\_\_\_  
Last First Initial Prefer to be called

Address \_\_\_\_\_  
Number and Street City State Zip Code

Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone (cell, work, other) (\_\_\_\_\_) \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Divorced  Separated Spouse's Name \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Have you or other family members been seen here before?  Yes  No

If so, list names \_\_\_\_\_

Who may we discuss your health information with?

No one other than self  Spouse  Parent  Voicemail (Cell/Home)  Other (Name) \_\_\_\_\_

May we leave detailed personal health information on your contact phone number voice mail?

This information may include pathology result, lab results, appointments, etc.

Home Phone:  Yes  No Alternate Phone:  Yes  No Business Phone:  Yes  No

**If patient is a minor (or student) indicate name of both parents or legal guardian:**

Father's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Mother's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Referring Physician \_\_\_\_\_ Family Physician \_\_\_\_\_  
or Pediatrician

Address \_\_\_\_\_ Address \_\_\_\_\_

**Bills To Be Sent To:**

Name \_\_\_\_\_

Address \_\_\_\_\_

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

**Insurance Authorization and Assignment / Consent to Treat**

I hereby give permission to Allergy & Asthma Physicians of Central Kentucky, PSC for the evaluation and treatment of the presented allergic or immunological condition.

I hereby authorize the physician(s) indicated above to release any medical information necessary to process my health insurance claim. I hereby authorize all payments of medical benefits to the physicians indicated above.

I have read the financial and privacy policy statements for Allergy & Asthma Physicians of Central Kentucky, PSC on the reverse side of this page and agree to the terms herein. I also understand that such terms may be amended when needed by the practice.

**Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

(See Reverse Side)

### **Financial:**

Our main goal is to provide the best care and service. We also recognize the need for a clear understanding of your financial obligations for the treatment you receive. In order to create a better understanding between patients and our practice, we have adopted the following policy. If you have any questions about this policy, we encourage you to contact our billing department.

### **Participating insurance plans:**

Medicare, Medicaid, United Healthcare, HMO-Kentucky, The Physicians Network, Anthem, Bluegrass Family Health, Cumberland Healthcare Inc., CHA, Aetna, PHCS, Cigna, Advantage Healthcare, and all Humana Plans. If your insurance plan is not listed above, it may be a part of one of the networks or considered out of network. You can call the number located on your insurance card to verify our participation.

### **Patients With No Insurance Coverage:**

Payment is due for all services the day they are rendered, unless other payment arrangements have been made with our billing department prior to the appointment. We do offer a discount for patients with accounts in good standing. Please call our billing department for details.

### **Patients With Out of Network Coverage:**

Our office will file claims on your behalf; however, you will not be eligible for our practice discounts. You will be responsible for all charges not covered by insurance.

### **Insurance Claims:**

**Co-payments are due at the time of service.** Patients must check with their insurance company regarding benefits including co-payments. In the event that your insurance card does not state your co-payment amount and you do not know the amount, we require a **\$25.00 co-payment**. To ensure that your claim is processed correctly, please provide us with a copy of your current insurance card. In the event that your insurance changes, please provide a copy of a new card to the front office.

Medicaid patients must present a card each visit that covers the date of service. If you do not have an updated card, you will be responsible to pay for services rendered.

**Extract services:** All patients must sign a financial/treatment consent form prior to vial preparation. Our office will contact your insurance company for benefit verification prior to this service.

### **Insurance Plans Requiring Referrals/Pre-Authorizations:**

Please check your insurance plan to see if a referral or pre-authorization is necessary from your primary care doctor to see our specialists. It is your responsibility to obtain the necessary referral in order for your insurance company to pay for your services. We will be happy to assist you in any way possible to obtain your required referral. If you arrive to your appointment without the referral, you can either reschedule the appointment when a referral can be secured or sign a waiver stating you do not have the necessary referral form and assume total financial responsibility for services that day.

### **Returned Checks:**

Due to the expense of processing checks returned by the bank, we charge a \$25.00 service fee. Any returned check must be paid within 14 days or it may be turned over to a collection agency.

### **Outstanding Balances:**

Delinquent balances must be paid in full before additional services can be provided, unless other arrangements have been made through our billing department. Delinquent balances over 90 days will be referred to an outside collection agency. **AAPCK reserves the right to dismiss patients with delinquent accounts.**

### **\*\*Minors:**

A parent or legal guardian **must** accompany all children under the **age of 18**. In the case of divorced parents, the parent bringing the child in for service is responsible for the bill unless court documentation is provided prior to the original appointment.

### **Other:**

We require a 24 hour notice from all patients when canceling your appointment. There will be a fee of **\$25.00 for follow-up appointments and \$50.00 for new patient appointments** that are not canceled in the time allotted.

### **Privacy:**

I have been offered and/or received a copy of Allergy & Asthma Physicians of Central Kentucky's Notice of Privacy Practices.