Academy Allergy Asthma & Sinus, PC

David L. Patterson, MD Tracy A. Donahue, CFNP, CPNP
(317) 621.2455

Patient Registration Information

First Name:	Middle Initial:	Last Name:	
SSN:	DOB:	Gender: M F	AKA:

Home Address:	City, State, Zip:
Home Phone:	Work Phone:
Cellular Phone:	Preferred Phone: ☐ Home ☐ Work ☐ Cell
Email:	Accept Texts for Appt. Confirmation? Y N

Race: ☐ Black/African American ☐ White/Caucasian ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander

Ethnicity: ☐ Hispanic ☐ non-Hispanic

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Pharmacy Name:	Pharmacy Address:
Primary Doctor:	Primary Doctor Phone:
Referring Doctor:	Referring Doctor Phone:

Person Responsible for Payment ☐ Check if patient address

First Name:	Last Name:	
DOB:	SSN:	Gender: M F
Home Address:		City, State, Zip:
Home Phone:	Work Phone:	
Cell Phone:	Fax:	
E-mail:		

Health Insurance Information

Insurance Name:		
ID Number:	Group Number:	
Insured First Name:	Middle Initial:	Last Name:
DOB:	SSN:	Gender: M F
Relationship to patient:		
Home Address:		☐ Check if patient address
City, State, Zip:		
Home Phone:	Work Phone:	
Cell Phone:	Fax:	
E-mail		

Emergency Contact

First Name:	Middle Name:	Last Name:
Home Phone	Work Phone:	
Cell Phone:	Relationship to Patient:	

Academy Allergy Asthma & Sinus

Patient Consent Agreement

Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your health care provider. We appreciate your confidence and trust.

The following is a statement of our policies that we require you to read and sign prior to treatment.

- I hereby consent to the physician and other persons acting under his direction and supervision to administer examination, treatments and other procedures as are deemed necessary.
- We will prepare and file insurance claims for the services you receive, but we require all co-payments and deductibles to be paid at the time of service, without exception. You are obligated and responsible to pay your portion.
- I understand that I am financially responsible for all amounts not paid by insurance. All balances are due within 30 days of the statement date.
- I hereby authorize the provider to release all information necessary to secure the payment of benefits. I designate Academy Allergy Asthma & Sinus, P.C. and its employees and agents as my representative to file grievances and to represent me with my insurance plan/HMO as allowed by Indiana State Law. I understand this authorization will remain in effect until revoked in writing.
- Even within the same insurance company, the plans may differ depending on what type of contract your employer has negotiated. Therefore, if you do not obtain the preauthorization required in your contract, and we subsequently treat you without the necessary authorization, we will have no choice but to bill you directly for the charges.
- Prescription refill requests are handled during office hours and may take up to 48 hours to process. There will be a $5.00 charge for lost prescriptions.
- There is a $10.00 charge to complete forms for school or insurance. The charge to complete forms for FMLA is $25.00.
- As a service to our patients, we will attempt to make a courtesy appointment reminder call. By providing your cell phone number, you consent to receive such calls at this number.
- Promptness is appreciated for all appointments. We require 24 hours notice if you need to cancel your appointment. (We have voice mail available after hours.) This will allow us time to offer your appointment to another patient. If you arrive fifteen or more minutes late for your appointment you may be asked to reschedule.
- A $45 charge will be assessed if you fail to provide the 24 hours advance notice when canceling or rescheduling an appointment. If three appointments are missed, our professional relationship with you will be terminated and you will be asked to seek treatment from another health care provider. In the event of severe weather, please phone the office for delay or closing information.
- Requests for copies of patient medical records will be subject to a fee as authorized by Indiana Law. If records are to be mailed, there will be an additional postage charge.
- I hereby agree to pay Academy Allergy Asthma & Sinus, P.C. the charges for all medical services rendered. In the event that I fail to pay the fees as agreed, I understand I will be responsible for all attorney fees, court costs and collection fees that may result from my failure to pay.
- I acknowledge receipt of this facility's Notice of Privacy Practices. (Available anytime on-line or in our office.)
- I acknowledge that I have read and agree to this Patient Consent Agreement and my questions have been answered. If I am agreeing and signing on behalf of a minor patient, I affirm that I have the legal right to consent and agree on behalf of that minor. I understand that I can request a copy of this document.

Patient (18 or over) or Legal Guardian Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____
(Person responsible for payment)

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Patient Authorization for Personal Representative

Patient Name: _____ Date of Birth: _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individuals who are authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy and request amendments to my protected health information. He/she may also consent to authorize the use or disclosure of my protected health information.

Name of 1st Personal Representative	Relationship to patient	Phone
Name of 2nd Personal Representative	Relationship to patient	Phone
Name of 3rd Personal Representative	Relationship to patient	Phone

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

Academy Allergy Asthma & Sinus, P.C.
Attention: Privacy Manager
14540 Prairie Lakes Boulevard North, Suite 207
Noblesville, IN 46060

- **Redisclosure:** We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Patient Signature: _____ Date: _____

Copies of signed authorizations are available upon request.