ADVANCED ALLERGY & ASTHMA SPECIALISTS

DENISE GONZáLEZ, MD

Diplomate of the American Board of Allergy and Immunology

CONSENT TO TREAT & VERIFICATION OF INSURANCE & BENEFITS

Patient's Name _____ **Date of Birth** _____ **SS#**_____ **Widow Sep Married Divorce**

Patient's Address _____ **City** _____ **State** ___ **Zip** _____ **Phone** _____

Email _____ **Patient's Driver's License** _____ **Languages** _____

Pt Education (grade finished) _____ **Career/Profession**_____ **Ethnicity** _____ **Race**_____

POLICY HOLDER'S NAME _____ **Date of Birth** _____ **SS#** _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Policy Holder's Driver's Lic # _____ **Phone #** _____ **Cell #** _____

Policy Holder's Employer _____ **Employer's Phone #** _____

Employer's Address _____ **City** _____ **State** _____ **Zip** _____

Emergency Contact _____ **Relation?** _____ **Phone #** _____ **Cell #** _____

Primary Care MD _____ **Phone #** _____

Primary Care Address _____ **City** _____ **State** ___ **Zip** _____

Pharmacy _____ **STORE # of Pharmacy** _____ **Address of Pharmacy** _____

Mail Away Pharmacy _____

___ ***I understand I am responsible for assuring AAAS is notified*** **of any changes in my Insurance coverage or Primary Care Physician** immediately upon change and prior to being seen subsequently.

___ ***I understand I am responsible for assuring any REFERRAL or AUTHORIZATION needed for my visits from my Primary Care Physician (PCP) or my Insurance are obtained and REMITTED TO AAAS PRIOR TO MY VISIT.***

___ ***I have read, understand and agree to the above responsibilities.***

___ I AUTHORIZE AAAS & DESIRE TO RECEIVE REASONABLE MEDICAL CARE BY TODAY'S STANDARDS.

_____ _____

Patient Signature or Responsible Party **Guardian or Responsible Party Name (PRINT)**

_____ _____

Witness Signature **Date**

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PT's APPT _____ ***INFO TAKEN BY*** ____ **Date of Verification** _____ **Ins Phone & Ext** _____

Insurance Co _____ **Insurance ID#**_____ **Group #** _____ **Eff Date** _____

Rep's Name _____ **Rep's Dept** _____ **City - State - Country** _____

Our MD in Network**? No Yes Referral needed? No Yes >** ***Referral Script*****? OR** ***Referral Authorization*** **#?**

Specialist Office Visit **Deductible? No Yes How Much?**_____ **How much is met?** _____ as of _____ date?

Specialist Visit **Co–Pay? No Yes How much?**_____ ***Specialist Visit*** **Co – Ins% ? No Yes How much?** _____

Allergy Skin Testing Covered? (95004 95024) Yes No Deduct /Co-pay/ Co-Ins apply to Skin Testing? Yes No

Pulmonary Fxns Covered? (94375 94060 94640) Yes No Deduct / Copay / Co-Ins apply to PFTs? Yes No

Lab Facility _____ **Radiology Facility** _____ **Ins Payer ID #** _____

Address to Send Paper Claim

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