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#**_____ **Is Patient Widow S M D Sep**

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 <u>PRIOR TO MY VISIT</u>.***

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

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

_____	_____	_____
Name of Patient	**Signature of Patient or Responsible Party**	**Guardian or Responsible Party (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** _____

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

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

<u>Specialist Visit</u> **<u>Co–Pay</u>? No Yes How much?**_____ ***<u>Specialist Visit</u>*** **<u>Co – Ins%</u> ? No Yes How much?** _____

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

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

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

Address to Send Paper Claim _____

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