RAA Redding Allergy & Asthma Center

PATIENT INFORMATION				
Patient's last name:	First name:		Middle initial:	
Birth date:	Age:		Sex: ☐ M ☐ F	
Street Address:	Phone no.:			
City:	State:		Zip Code:	
Email address:	Marital status (if applicable): Single ☐ Married ☐			
If patient is a child, please list names of legal guardians and contact numbers:				
Legal guardian (1):	Phone no.:			
Legal guardian (2):	Phone no.:			
Referred to clinic by (please check all boxes that apply):	☐ Physician: Dr.	☐ Friends/Family	☐ Website	
☐ Insurance company	☐ Advertisement	☐ Other:		

INSURANCE INFORMATION					
Is this patient covered by insurance? ☐ Yes ☐ No					
Please indicate primary insurance:	☐ Aetna	☐ BCBS	☐ Cigna/Great West	☐ Coventry	☐ Humana
☐ Medicare	☐ PHCS	☐ UHC	☐ Other:		
Subscriber's name:	Subscriber's Birth date:				
Patient's relationship to subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other:		
Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber's Birth date:			
Name of emergency contact:	Relationship to patient:	Home phone no.:	Work phone no.:		

ADDITIONAL INFORMATION
Please be aware that this office does not use an answering service after business hours. If you need emergency assistance after the office has closed, please go to your nearest emergency room.
The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Redding Allergy and Asthma Center to release any information required to process my claims.
Patient/Guardian signature Date

REDDING ALLERGY & ASTHMA CENTER

NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this protected health information can and may be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party administrators
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Policy containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Policy and that I may contact Redding Allergy and Asthma Center at any time at the address above to obtain a current copy of the Notice of Privacy Policy.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound by those restrictions.

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY
I attempted to obtain the patient/guardian's signature in acknowledgement of this Notice of Privacy Policy Acknowledgement, but was unable to do so as documented below:

Patient Name: _____

Comments:_____

Initials: _____ Date: _____

REDDING ALLERGY & ASTHMA CENTER

Patient Financial Agreement

At Redding Allergy and Asthma Center, we require patients to arrange for payment for all billed services at the time of service. This helps us reduce our administrative costs, so we can keep the cost of our services affordable.

Here's how it works:

- **You will be asked for a credit card or debit card when you check in**
- **We will store this account number in your medical record**
- **Your card will only be charged once the Explanation of Benefits – which identifies your responsibility for the charges – is issued by your insurance company**

Please note that we are contracted with numerous insurance companies, and will file your claim as a courtesy to you. Because every plan has different stipulations regarding access to care and payment for services received, it is your responsibility to understand your benefits.

If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and your insurance company does not cover these charges, we will bill you directly. This is also our policy in the event of claim refutations, such as medical necessity or pre-existing condition denials.

Please remember that you, the patient, are ultimately responsible for payment on your account. If you have any questions regarding our financial policy or your account, please call our office at 404-355-0078.

Please sign below to acknowledge that you have read the above information and agree to authorize payment on the date of service for all services rendered.

Patient/Guardian Signature: _____Date:_____

Examples of approximate fees are listed on the last page of this packet

RAA Redding Allergy & Asthma Center

Dear Patients:

As your trusted source of allergy and asthma care, we want to introduce you to our newest medical device designed to better diagnose and monitor your asthma. Along our continuous search for the latest technology, we found the **NIOX MINO® Airway Inflammatory Monitoring System**. Along with the tools we currently use to look at how successful pharmaceutical therapy has been, the NIOX MINO will be an additional measure that tells us your level of lung inflammation. The device employs an easy and non-invasive method of a simple 10 second exhalation that you will find completely painless and even a little fun.

Just a few of the many benefits of this new technology are:

- The possibilities of lowering your dose of medication when appropriate
- The ability to adjust medication based on your individual needs
- Insight into your treatments efficacy
- Better prediction of asthma relapse and exacerbation
- Early identification and close monitoring or airway inflammation

We value your trust in us and will continue to offer the most sensitive and accurate ways to best control your asthma and its symptoms.

Please note: If the test is performed, we will bill your insurance provider for the appropriate charge. If the charge is not covered, you may receive a bill for $25.00 to cover the medical costs of performing this sensitive measurement. If you do not wish to be charged for this test please notify the staff prior to performing the test. Thank you!

Patient/Guardian Signature: _____Date:_____

REDDING ALLERGY & ASTHMA CENTER

NOTICE

APPROXIMATION OF ALLOWABLE FEES

NEW PATIENT APPOINTMENT: $150

ALLERGY SKIN TESTING: $450

SPIROMETRY: $50-100

EXHALED NITRIC OXIDE MEASUREMENT: $25

The fee ranges listed above are an estimation of the charges generally allowed by insurance companies. Please be aware that if you have not met your deductible, you may be responsible for the full amount of the charges allowed by your insurance company. Please note that these fees are only an approximation, and they do not necessarily represent actual allowed amounts by an insurance company.