ALLERGY, ASTHMA, SINUS & IMMUNOLOGY CENTER
Shawky A Hassan, M.D., Ph. D.
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PATIENT REGISTRATION

PLEASE PRINT CLEARLY ALL THE REQUESTED INFORMATION. THANKS.

GUARANTOR INFORMATION

LAST	FIRST NAME	INITIAL	Home Phone	Work Phone	Cell Phone

ADDRESS	CITY	STATE	ZIP CODE	EMERGENCY PHONE & CONTACT PERSON

OUT OF TOWN ADDRESS	CITY	STATE	ZIP CODE	OUT OF TOWN PHONE

SOCIAL SECURITY NO.	DRIVER'S LICENSE NO.	E-MAIL

EMPLOYER	EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

PATIENT INFORMATION

PATIENT NAME	BIRTH DATE	O MALE O FEMALE O CHILD O SINGLE O MARRIED O DIVORCED O SEPARATED O WIDOW

ADDRESS IF DIFFERENT FROM ABOVE	REFERRING PHYSICIAN OR OTHER SOURCE OF REFERRAL	FAMILY PHYSICIAN

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER & ADDRESS	GROUP NO.	CONTRACT NO.

SECONDARY INSURANCE CARRIER & ADDRESS	GROUP NO.	CONTRACT NO.

NAME OF INSURED	BIRTH DATE	RELATION TO PATIENT

FEES & BILLING INFORMATION

Our billing procedures are clear. Please take a few moments and acquaint yourself with our credit policy:

1. **Payment is expected at the time of service by cash, check or credit card (Visa/Master Card).**
2. **You will receive an itemized statement for all services rendered to you on the same day of service.**
3. **All accounts past due over 60 days are to be paid by the patient prior to the next visit.**
4. **A rebilling charge of 1 ½% per month will be added to any unpaid balance over 60 days from the day of service.**
5. **All accounts 90 days or older are handled exclusively by a collection agency and a collection fee will be added to the balance.**

AUTHORIZATION (PLEASE READ CAREFULLY BEFORE SIGNING)

1. **I consent to and authorize this medical facility, its doctors and staff to diagnose and treat my condition.**
2. **No promise for cure has been given to me.**
3. **My signature below can act as a signature on file for filing insurance claims on my behalf.**
4. **I authorize the release of medical information needed to establish my claim.**
5. **I understand this office cannot accept the responsibility for collecting my insurance claims.**
6. **I understand this office cannot accept the responsibility of negotiating a settlement of my claim.**
7. **I acknowledge the initial visit charges have been explained to me at the time I made the appointment.**
8. **I understand the billing, fees and credit policies of this facility as outlined above.**
9. **I understand the provider's charge may exceed the insurance payment and if greater than such payment, I am responsible for the amount.**
10. **I acknowledge that I have access to the notice of Privacy Practices (HIPPA) located in a three ring binder at your business office desk and that I will read it, if I so choose.**

SIGNATURE	DATE	WITNESS

BELOW FOR OFFICE USE ONLY… INSURANCE COVERAGE %

OFFICE VISITS _____ LAB TESTS _____ ALLERGY TESTING _____ ALLERGY INJECTIONS_____ ALLERGY EXTRACTS_____ VERIFACATION NO. _____

EFFECTIVE DATE: _____ DEDUCTABLE: _____MET _____ NOT MET _____COPAY_____VERIFIED BY_____DATE_____