FREEDOM ALLERGY
ALLERGY SINUS AND COUGH CENTER

Ruchir Agrawal, MD
115 Genevieve Court, Peachtree City, GA 30269

Patient Registration Form

Today's Date:_____

Patient Name:_____ Patient Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____ Gender: male female

Marital Status: Married Single Divorced Other

Preferred Language: English Other

Ethnicity:

Hispanic/Latino Caucasian African American Asian Prefer not to answer

Employer:_____ Work Phone:_____

Social Security #:_____ Driver's License #:_____

Parent/Guardian Information
(if patient is under 18 years of age)

Parent/Guardian Name:_____ Relation to Patient:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Work Phone:_____

Social Security #:_____ Driver's License #:_____

Insurance Information

Primary Insurance Company:_____

Address:_____

City:_____ State:_____ Zip:_____

ID Number:_____ Group Number:_____

Guarantor Name:_____ Guarantor DOB:_____

Guarantor Employer:_____

Guarantor Relationship to Patient:_____

Secondary Insurance Company:_____

Address:_____

City:_____ State:_____ Zip:_____

ID Number:_____ Group Number:_____

Guarantor Name:_____ Guarantor DOB:_____

Guarantor Employer:_____

Guarantor Relationship to Patient:_____

Other Information

Pharmacy Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Primary Doctor Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Doctor Phone:_____ Doctor Fax:_____

Referred by:_____

How did you hear about us? friend family doctor flyer community event internet search Facebook www.oit101.org

Financial Policy

I authorize the release of any information necessary to process claims. I request payment of benefits to Freedom Allergy. I understand I am financially responsible for charges not covered by insurance.

If your plan has a co-payment, deductible, and/or co-insurance, you will be expected to pay your portion prior to receiving any service including an office visit and/or immunotherapy. If you are on a high deductible plan, you will be required to pay a minimum of 50% at the time of service until we verify your deductible has been met.

Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. Should it become necessary for Freedom Allergy to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/or attorney fees.

I understand and agree if care at Freedom Allergy requires a primary care physician referral, it is my responsibility to see that the referral is current prior to receiving care at Freedom Allergy. If no referral is present in advance, I agree to pay for charges at the time of services.

I have read the above Freedom Allergy financial policy and understand my financial responsibility.

Patient/Responsible Party Signature:_____

Date:_____

HIPAA Acknowledgement and Consent Forms

1. Acknowledgement of Practice's Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation will not be retroactive.

This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, I understand that:

• Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

• The Practice reserves the right to change the Notice of Privacy Practices as allowed by law.

• The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.

• The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

• The Practice may condition receipt of treatment upon execution of this Consent.

This consent was signed by:

_____ _____

Patient's Name (Printed) DOB (mm/dd/yyyy)

_____ _____

Signed (Patient/Legal Representative) Date

Relationship to Patient (if other than patient):_____

2. Request to Receive Confidential Communications by Alternative Means

As provided by Privacy Rule Section 164.522(b), I hereby give permission for Freedom Allergy to communicate to me about appointments, lab results, and/or patient care by phone messages, texts, email, or fax.

Phone Number:_____

Email Address:_____
Fax:_____

_____ _____

Signed (Patient/Legal Representative) Date

3. Adult Consent to Share Medical Information*

I agree that the Freedom Allergy may disclose certain pieces of my health information to a person of my choosing, since such person is involved with my healthcare or payment relating to my healthcare.

I give permission for Freedom Allergy to disclose the following information (initial below):

- Scheduling appointments _____
- Lab Results _____
- All information regarding assessment, diagnosis, and treatment of my medical condition, including oral immunotherapy, immunotherapy,
- and other allergic treatments. _____
- Other _____

The indicated information may be disclosed either phone or email to:

Name:	**Relationship to Patient:**	**Phone #:**	**Email:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____

Patient's Name (Printed) DOB (mm/dd/yy)

_____ _____

Patient's Signature* Date

*Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law.

*Patient can cancel this authorization in writing at any time.