

Thank you for choosing Dr. Sran and the staff of Allergy & Asthma Assoc. for your allergy care. To make your initial visit pleasant and informative, we offer the following information about our practice.

In addition to reviewing this information letter, please download and print all “new patient forms” from this web site and bring the completed forms along with current insurance card and photo identification.

During your visit a complete health and family history will be obtained. Please take time before the appointment to make note of illnesses, diseases, surgeries and any family history of allergies. Also helpful will be a current list of medications and names and addresses of any previous physicians.

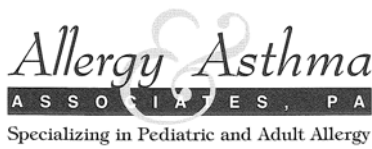
Your visit will consist of a complete medical history, physical exam and. If indicated, testing for allergies and asthma. We believe after this complete evaluation, a discussion of your treatment plan with you and your family is very important. You will then be given a written treatment plan specifically created for you to take home.

A complete evaluation can last 1 ½ to 2 ½ hours so we do ask that you allow ample time for this visit. Because of the time allotted for this evaluation, we kindly ask that you contact our office at least 48 hours prior to your scheduled appointment should you need to reschedule. A missed appointment fee may be imposed if notice is not received by our office.

Allergy testing may be necessary to determine the cause of your symptoms. We ask that you discontinue antihistamines 5-7 days prior your visit. Allergy testing may not be done if you taking B-blocker medications, however, you should NOT stop these unless you have consulted with your personal physician. Most medications for asthma do not have to be stopped. Please call our office if you have any questions concerning medications.

Our office accepts most insurance plans and we will kindly assist you in obtaining payment for our services. Please be prepared to take care of co-payment or deductible at the time of your visit unless other arrangements are made prior to the visit with the billing department. A current insurance card and photo identification should be brought to every visit.

We look forward to your visit to our office. If you have any questions or concerns, please call our staff and we will be happy to assist you. Thank you again for trusting Allergy & Asthma Assoc. with your allergy care.



SARBJEET K. SRAN, M.D.

Home phone _____ Family Doctor: _____
Cell phone _____ Referring Doctor: _____
(If patient is a minor)
Mother's cell phone _____
Father's cell phone _____
Email address _____

Patient's Full Name: _____
(Last) (First) (Middle)
Street Address _____ City _____ State _____ Zip _____
Billing Address (if different from Street Address) _____
Patient's Date of Birth _____ Sex - Male or Female _____ SS# _____
Married or Single _____
Employer's Name _____ Department _____
Address _____ Phone: _____ ext _____

Please complete if a minor

Father's Name _____ Mother's Name _____
Employer Name & Address _____ Employer Name & Address _____
Employer's Telephone _____ Employer's Telephone _____
Name of school that child attends _____
Address: _____

Closest Relative's Name, Address, and Telephone (Not Living with Patient): _____

Referred to our office by: _____

Insurance Information

Primary Secondary
Policy Holder: _____ Policy Holder: _____
Date of Birth: _____ Date of Birth: _____
ID Number: _____ ID Number: _____
Group Number: _____ Group Number: _____
Insured SS #: _____ Insured SS #: _____

Authorization to treat

I hereby authorize the providers of Allergy & Asthma Associates to provide medical care and treatment to either me or my child. I certify that the above information is accurate

Signature _____ Date _____

FINANCIAL POLICY

The following information is provided to the patients of Allergy & Assoc. to acquaint them with the financial policies of the practice. Please direct any questions to the billing or management staff. The providers of the practice do not address financial matters.

- Current insurance information must be presented to our staff upon arrival/check-in in order to file timely and accurate claims. Failure to provide this information will delay processing and may result in service charges on the account.
- All copayment amounts are due at the time of service. This includes office visits, allergy injections and allergy extracts. If you or a family member receives weekly injections and you wish to pay monthly, please discuss this financial arrangement with the staff. This can certainly be arranged for your convenience, however, failure to remit payments at the end of the month may result in suspension of this practice.
- If you have no medical insurance, payment for service is due at the time of service. Again, if needed, we can discuss financial arrangements.
- Allergy extract (the medicine received in shots) will be mixed and billed from our office based on the need of each patient. We will be unable to mix an extract if the previous order has not yet been paid. For that reason, please monitor your insurance explanations of benefits that are sent directly to you from your carrier. We make every effort to assist you in collecting the payments for services but it is sometimes necessary for you, the policyholder, to become involved in this process
- Monthly statements are sent to each responsible party showing the current amount due to the practice as well as the outstanding amounts due from the insurance carrier. The amount due as indicated on the statement is due. Any payments made 30 days after the statement date is considered past due. If no payment or arrangement for payment is made after 60 days, the account is classified as delinquent and after 90 days is forwarded to an agency for collection proceedings. When an agency becomes involved the computer system then “switches” all future transactions to a “cash only” basis.
- You may be reminded by phone or letter of the current status of your account. We realize that errors can occur and wish to assist you in any way that we can. Please welcome this communication as our way of insuring continuation of a financial agreement between you and the practice.

If you wish to discuss any financial matters, please call during our normal operating hours.

I have read and understand the financial policies of Allergy & Associates.

Signature: _____ Date: _____

Patient Confidentiality Agreement

Due to new regulations in the health care industry, our office is no longer allowed to leave messages in regard to a patient's appointments, laboratory results or any information pertaining to medical treatment, on answering machines or other electronic devices without the signed consent of the patient.

Please Read, Sign and Date:

I, _____, sign this agreement which allows Allergy & Associates or its employees to use voice mail, answering machines, mail or other means of communication to inform me of appointments, lab results or other treatment information.

Date: _____

**Acknowledgement of Receipt
of Notice of Privacy Practices:**

Patient Name & Address:

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.**
- The individual refused to sign.**
- A copy was mailed with a request for a signature by return mail.**
- Unable to communicate with the patient for the following reason:**

- Other:**

Prepared By: _____

Signature: _____

Date: _____