

FAMILY ALLERGY CENTER, P.C.

13890 BRADDOCK ROAD SUITE 206 • CENTREVILLE, VIRGINIA 20121-2437 • (703) 263-2333 • FAX (703) 263-0361

KENNETH R. BERGMAN, M.D.
TAMARA S. SMITH, M.D., MPH
CATHERINE THAL-LARSEN, F.N.P.

NAME:

First	Middle Initial	Last
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ADDRESS:

Street/Box/Apt.	City	State	Zip
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PHONE: Home _____ Work _____ Cell _____

AGE: _____ BIRTHDATE: _____ SOCIAL SECURITY #: _____

SEX: (circle) Male Female MARITAL STATUS: (circle) Single Married Separated Divorced Widowed

PRIMARY DOCTOR: _____ Address: _____ Phone: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PATIENT EMPLOYMENT INFORMATION

EMPLOYER: _____ POSITION: _____ EMPLOYER PHONE#: () _____

EMPLOYMENT ADDRESS: _____

DEPENDENT CHILD INFORMATION:

MOTHER/GUARDIAN INFORMATION: NAME: _____ SSN: _____

HOME ADDRESS: (if different than above): _____ Home Phone: _____

EMPLOYER: _____ POSITION: _____ EMPLOYER PHONE#:() _____

FATHER/GUARDIAN INFORMATION: NAME: _____ SSN: _____

HOME ADDRESS: (if different than above): _____ Home Phone: _____

EMPLOYER: _____ POSITION: _____ EMPLOYER PHONE#:() _____

PERSON RESPONSIBLE FOR PAYMENT (Circle one): Father Mother Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ INSURED'S NAME: _____

INSURED SSN#: _____ ID#: _____ GROUP #: _____

RELATIONSHIP TO PATIENT: _____ INSURED DATE OF BIRTH: _____

RELEASE OF INFORMATION/PAYMENT AUTHORIZATION

Please read and sign the following:

I, (Please print) _____ accept all responsibility for any unpaid claims that are rejected because the Family Allergy Center, P.C. did not have my correct or current information and/or did not have a current or correct referral from my primary care physician.

X _____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of benefits to the Family Allergy Center, P.C. for services provided.

X _____

Because we are specialists, we do not provide primary care. If you do not already have a primary care physician, we will be glad to assist you in finding one. Routine physicals, non-allergenic problems, acute infections, and emergencies should be referred to your primary care doctor. We will send a report on your allergy evaluation to your referring physician, and provide continuing care for your allergy problems.

X _____

Family Allergy Center, P.C. will submit a claim to your insurance on your behalf and make every effort to collect on that claim. However, if your insurance has not responded and/or paid within **90 days** of having filed a claim, we will transfer the balance to the patient for assistance with collection of debt for services rendered. After **90 days**, the balance will become the patient's responsibility. By signing below, you agree that in the event your claim is not paid, you shall be responsible for and shall pay for services rendered.

X _____

I understand that I may be charged a missed appointment fee of up to **\$50.00** if I fail to give 24 hours notice of cancellation to Family Allergy Center.

X _____

Please provide our office with up to two names of persons other than yourself to whom you allow the Family Allergy Center, P.C. to release protected medical information.

1) _____
Relationship to patient

2) _____
Relationship to patient

EMERGENCY CONTACT: _____ **RELATIONSHIP TO PATIENT:** _____

PHONE #: _____