DFW Asthma & Allergy Center

**New Patient Paperwork/
Updated Demographics for existing patients**

4674 McDermott Rd. #310
Plano, TX-75024

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Last Name ______________________________ First Name ______________________________ MI ________

Street Address ______________________________ APT # __________ City ______________ State ________ Zip ________

Home Phone ______________________ Work Phone ______________________ Cell Phone ______________________

Email Address ____ Date of Birth ______________________

Social Security ______________________ Preferred Pharmacy Name ____

Preferred Pharmacy Address ____

Emergency Contact Name ______________________________ Emergency Contact Number ______________________

PCP Name ____ PCP Phone Number ______________________

Ethnicity: □ White/Caucasian □ Black/African American □ Hispanic/Latino □ Asian □ Native Hawaiian/Pacific Islander □ Other

Race: □ Hispanic/Latino □ Not Hispanic/Latino □ Patient Declines to provide

Primary Insurance Name, Phone, Address ____

Name of Insured ______________________________ DOB ____________ Relationship ______________________

Insured's ID Number ______________________ Group Number __________ Insurance Type: HMO PPO POS PO INDEM

Secondary Insurance Name, Phone, Address ____

Name of Insured ______________________________ DOB ____________ Relationship ______________________

Insured's ID Number ______________________ Group Number ______________ Insurance Type: HMO PPO POS PO INDEM

I hereby authorize payment of medical benefits billed to my insurance by ***DFW Asthma & Allergy Center***. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered. I authorize the release of any medical information necessary to process an insurance claim and also request payment of government benefits either to myself or to the party who accepts assignment below

Signature of Patient or Guardian (if patient is under 18*) ______________________________ Date ______________________

*IF PATIENT UNDER AGE 18, Dr. Ghazi and staff have my permission to exam and treat

How did you find us: Google ZocDoc Yelp Other ____

FINANCIAL POLICY

Thank you for selecting our practice for your allergy and asthma needs. Our goal is to provide you with the highest quality of treatment and service. Your complete understanding of your financial responsibilities is an essential element of your care.

1. Patients are responsible for all payments including, but not limited to co-pays, co-insurance, deductibles, and past due balances **at the time of service**. **We accept cash, check, debit cards, MasterCard, Discover, American Express, and Visa.**

2. Insurance Policies: We are contracted providers with many insurance plans and will accept assignment of benefits. As a courtesy, we will bill your primary insurance policy to the plans with which we participate. If your insurance company denies your bill, you are ultimately responsible for payment of services not covered by your insurance plan and will be held financially responsible. It is your responsibility to call and check with you insurance as to which services are covered prior to being seen and treated. We do not file on secondary insurances, other than Medicare. **If you are in a "grace period" with your insurance, you will be expected to pay the full self-pay cost of the visit at the time of service. This will be refunded to you once your premiums have been paid, and your insurance processes the claim.**

3. All health plans are not the same and do not cover the same services. In the event your insurance plan determines a service to be "not covered," or "not medically necessary", or you do not have an authorization, you will be responsible for the complete charge.

4. If you are out-of-network, payment is still due in full at the time of service. We will prepare a receipt for you at the time of service with all the necessary information needed for you to file the claim.

5. You must inform the office of all insurance changes, authorization referral requirements, address changes at the front desk. In the event the office is not informed before care is rendered, you will be responsible for any charges that are denied.

6. In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges on the date of the child's office visit. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

7. You may receive a separate bill for laboratory or pathology services from an off-site lab for any tests your physician orders. In the case you receive a bill from an outside lab; you may discuss any bills with that lab.

8. Please call us at least 24 hours before your appointment time if you need to reschedule, change, or cancel an appointment. A $25 charge will be applied for any appointment that is not cancelled at least 24 hours prior to your appointment time. A $50 charge will be applied for any Saturday appointment that is not cancelled at least 24 hours prior to your appointment time. Patients with multiple missed appointments or cancellations will be discharged from DFW Asthma and Allergy Center.

9. Request of Medical Records -We will provide this information within 15 days from receipt of request and that a fee of $25 for the FIRST 20 pages and $.50 for each additional page for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

10. A $40 returned check fee will be charged for all returned checks.

11. If your account is past due, you will be assessed late fees and interest. Your account may be turned over to a collection agency, and you will be responsible for the collection fee charged to us by the agency in the amount of $50, and all attorneys' fees (including litigation, if necessary) in addition to your original outstanding balance.

I have read and understand the financial policy of DFW Allergy and Asthma Center, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

Print Name____

Signature____ Date____________________