BOULDER VALLEY ASTHMA AND ALLERGY

PATIENT REGISTRATION FORM

Acct # ________________

Patient Information

Legal First Name ______________________ M.I. ____ Last Name ______________________

Address ____
Street City State Zip

Home Phone ________________ Cell Phone ________________ Email ________________

Employer ______________________ Work # ______________________

Birth Date ______ / ______ / ______ Social Security # ________________ or Drivers License # ________________

Gender: M / F **Marital Status:** Married Single Divorced Other **Preferred Language:** English Other ________

Ethnicity: Hispanic/Latino Non Hispanic/Latino **Race:** Caucasian African American Asian Other ________

Referred by ______________________ Primary Physician ______________________

Responsible Party

Legal First Name ______________________ M.I. ____ Last Name ______________________

Address ____
Street City State Zip

Home Phone ________________ Cell Phone ________________ Email ________________

Birth Date ______ / ______ / ______ **Gender:** M / F

Social Security # ________________ or Drivers License # ________________

Employer ______________________ Work # ______________________

Insurance Information

Primary Insurance Company ____

Address ____
Street City State Zip

ID Number ______________________ Group Number ______________________

Insured Name ______________________ Insured DOB ______________________

Insured Employer ______________________ Relationship to Patient ______________________

Secondary Insurance Company ____

Address ____
Street City State Zip

ID Number ______________________ Group Number ______________________

Insured Name ______________________ Insured DOB ______________________

Insured Employer ______________________ Relationship to Patient ______________________

Financial Policy: I authorize the release of any information necessary to process claims. I request payment of benefits to Boulder Valley Asthma and Allergy Clinics, PC (BVAAC). 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 that your deductible has been met or other arrangements have been made. **Boulder Valley Asthma and Allergy Clinics, PC accepts most major insurance plans however there may be plans which we are excluded from participating in. It is your responsibility to verify that BVAAC is a participating provider with your specific plan.** In the case of a divorce situation, the adult accompanying a minor patient is responsible for payment of services. Our office staff will not participate in any disputes which may arise with respect to financial liability due to legal custody agreements. 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 BVAAC 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 that if my treatment at BVAAC requires a primary care physician referral, it is my responsibility to see that the referral is current and valid prior to receiving care at BVAAC. If no referral is present in advance, I agree to pay for charges at the time services are rendered. BVAAC accepts cash, checks, Visa, Mastercard and Discover for your convenience.

Patient/Responsible Party Signature ______________________________ **Date** ______________

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Appointment Cancellation/No Show Policy

Boulder Valley Asthma and Allergy Clinics, PC understands that there are times when you must miss an appointment due to an emergency or unforeseen circumstances. However, when you do not call to cancel your appointment, you may be preventing another patient from receiving much needed medical care. If you need to cancel your appointment to see a BVAAC physician you must do so within 24 hours of the appointment or you will be charged a $50 cancellation fee. This fee will not be covered by your insurance.

You need to speak directly with a BVAAC staff member to cancel an appointment and avoid the late cancellation charge.

Tardy Policy

We understand that delays can happen however we must try to keep other patients and physicians on time. If a patient arrives 15 minutes past their scheduled check in time, we will have to reschedule the appointment.

I have read the above Boulder Valley Asthma and Allergy Clinics, PC financial policy, appointment cancellation, no show and tardy policies and understand that it is my responsibility to contact the office the reschedule or cancel my appointment if necessary.

Patient/Responsible Party Signature ____ **Date** ____________________