Food Allergy Center of Florida

Windom Allergy, Asthma & Sinus

SCR Sarasota Clinical Research

Hugh H. Windom, MD   Jean Ly, MD   Jennifer Fergeson, DO   Tara Saco, MD

PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date: ____________________

Last Name: ____________________

First Name: ____________________ MI: ________

Mailing Address: ____________________

____

City: ____________ State: ________ Zip: ________

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

Primary Care Physician: ____________________

Address/Phone: ____________________

Date of Birth: ____________ Sex: ________

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Widowed

(Check One) ☐ Employed ☐ Retired ☐ Disabled

☐ Self Employed ☐ Unemployed

☐ Full-Time Student ☐ Part-Time Student

Race: ☐ White/Caucasian ☐ Black/African American

☐ Asian ☐ Hispanic/Latino ☐ Native American

☐ Other ____________________

Language: ☐ English ☐ Spanish

☐ Other: ____________________

RESPONSIBLE PARTY/PARENT

Last Name: ____________________

First Name: ____________________ MI: ________

Relationship to Patient: ☐ Self ☐ Other: ____________

Phone Number: ____________________

Address: ☐ Check here if same as patient

____

City: ____________ State: ________ Zip: ________

EMERGENCY CONTACT

Last Name: ____________________

First Name: ____________________ MI: ________

Relationship to Patient: ____________________

Phone Number: ____________________

Address: ☐ Check here if same as patient

____

City: ____________ State: ________ Zip: ________

PRIMARY INSURANCE INFORMATION

(Please provide your insurance card to the front desk at check-in)

Insurance Company: ____________________

Policyholder's Name: ____________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policyholder's Birthdate: ____________________

Policyholder's Phone Number: ____________________

SECONDARY INSURANCE INFORMATION

(Please provide your insurance card to the front desk at check-in)

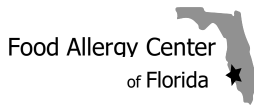
Insurance Company: ____________________

Policyholder's Name: ____________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policyholder's Birthdate: ____________________

Policyholder's Phone Number: ____________________



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PREFERRED PHARMACY

Pharmacy Name: ____

Address: ______________________ City/State: ________________ Zip: __________

ALTERNATE/NORTHERN ADDRESS

Street Address: ____

City: ______________________ | State: ______________ Zip: __________

HOW DID YOU HEAR ABOUT US?

☐ Referred by doctor ☐ Word of mouth-family, friend, etc. ☐ Insurance company ☐ Internet ☐ Old patient ☐ Other

PLEASE READ THE FOLLOWING INFORMATION

Our Policy Regarding Patient Financial Responsibility

Insurance. Windom Allergy, Asthma & Sinus files insurance claims for insurance plans with which we participate. We accept payment for covered services from these insurance plans in accordance with our contract. Our patients are responsible for applicable co-insurance and deductible amounts. Our patients are also responsible for any and all payments for services that are not covered by insurance. The patient is responsible for payment of amounts they owe at the time of the service.

Medicare. Windom Allergy, Asthma & Sinus files insurance claims for Medicare on assignment. We accept Medicare allowable amounts as payment and the patient is responsible for charges applied to their deductible, any co-insurance and non-covered charges.

Self-Pay. All services are required to be paid in full at time of service.

Diagnostic Testing. Allergy skin testing, breathing tests, and/or fiberoptic nasopharyngeal examinations, if recommended by the doctor, will be an additional charge separate from your office visit. These and all charges are due at the time of service. Ultimately it is your responsibility to know the benefits of your insurance plan. We are happy to provide you with an estimate of your total out of pocket cost.

Cancellations. Windom Allergy, Asthma & Sinus asks that you notify us if you are unable to keep your appointment. This courtesy will allow us to schedule another patient who needs to be seen. Patients who consistently fail to show for their appointments and/ or fail to notify us may be asked to find another physician outside Windom Allergy, Asthma & Sinus.

I have read and understand the office policy stated above and agree to accept the responsibility described. I hereby authorize the assignment of benefits (payments) directly to **Windom Allergy, Asthma & Sinus** for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Patient Signature: ______________________________ Date: ______________

Responsible Party Signature: ______________________________ Date: ______________
(if different than patient)

Responsible Party Name (Please Print): ______________________________

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Acknowledgement of Notice of Privacy Practices & Consent for Communication and/or Disclosure

Patient Name: ________________________________ **Date of Birth:** ____________________

I have received this practice's Notice of Privacy Policy written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Policy, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

I understand the office enrolls interested patients in Clinical Trials of new medications. If my medical record indicates that I may qualify for participation, I may be contacted with information about the study.

I wish to be contacted in the following manner: (please check all that apply)

- ☐ Cell Phone (________)__________-____________________________
- ☐ Home Phone (________)__________-____________________________
- ☐ Work Phone (________)__________-____________________________
- ☐ Email Email Address: ____________________________________

I give my permission to share information with the person(s) names below:

Name: ______________________ Relationship: __________ Phone: ____________

Name: ______________________ Relationship: __________ Phone: ____________

Name: ______________________ Relationship: __________ Phone: ____________

Signature: ________________________________ **Date:** ____________________

Relationship to patient (if signed by a personal representative of patient): ______________________