Food Allergy Center of Florida

Windom Allergy, Asthma & Sinus

SCR Sarasota Clinical Research

Jean Ly, MD | Hugh H. Windom, MD | Jennifer Fergeson

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 Provider: _____

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: _____

Address: ☐ Check here if same as patient

_____

City: _____ State: _____ Zip: _____

Phone Number: _____

EMERGENY CONTACT

Last Name: _____

First Name: _____ MI: _____

Relationship to Patient: _____

Address: ☐ Check here if same as patient

_____

City: _____ State: _____ Zip: _____

Phone Number: _____

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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ALTERNATE/NORTHERN ADDRESS
Street Address: _____
City: _____ State: _____ Zip: _____
PREFERRED PHARMACY
Pharmacy Name: _____
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): _____