Vital Allergy & Asthma Center
adding vitality to life by eliminating allergies!

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Board Certified Adult & Pediatric Allergy, Asthma & Immunology

WELCOME TO OUR OFFICE

Patient's Name:____ Today's Date:_____________________
First Middle Last

Home Address:_________________________________ City:_________________ State:_____ Zip:____________

Telephone: Home (_____)________________ Cellular: (_____)________________ Work: (_____)________________

Email: Personal___________________________________ Work_______________________________________

DOB:_________________ Age: _________ SSN#:____________________ Ethnic Background:_________________

Sex:_________ Occupation:________________________ Married/Single:__________________________________

Pharmacy Name/Address: _________________________________ Phone(_____)__________________________

Employer:____ Length of Employment:_________________________

Employer's Address:______________________________ City:_________________ State:______ Zip:___________

Employer's Telephone: (_____)________________________ Driver's License #:______________________________

Name of Spouse/Parent:_____________________________________ DOB:________________ Age:__________

Occupation:____ SSN#:____________________________________

Employer:____ Length of Employment:_________________________

Employer's Address:______________________________ City:_________________ State:______ Zip:___________

Employer's Telephone: (_____)________________________ Driver's License #:______________________________

Has our physician seen any of your family members? Yes or No. If Yes, please state name and relationship to you:____

COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE:

Responsible Party:__________________________ Relation to Patient:_____________________ DOB:____________

Home Address:_________________________________ City:_________________ State:_____ Zip:____________

Telephone: (_____)___________________ Occupation:____

Employer: _________________________________ Employer's Telephone: (____)__________________________

Employer's Address:_____________________________ City:__________________ State:______ Zip:___________

Notice To All Patients

Please be very careful when filling in the insurance information, our office uses it to file your insurance. Please inform our office if your insurance changes at any time so that we may file accordingly. Our office will NOT be responsible for claims paid at an incorrect rate if you have provided us with improper information.

Name of Primary Insurance Company:____

Policy Holder (Employer Name):____

Subscriber (Employee Name):____

Subscriber SSN#:________________________ Group Number :__________________________Policy #:________________

Claims Address:____ Insurance Co. Phone:________________________

In Case of Emergency, Contact:__________________________________ Relationship:______________________________

Day Phone:____________________________________ Evening Phone:____

How did you hear about Vital Allergy & Asthma Center?____

Referring Doctor:_________________________________ Address:____

Primary Care Doctor:______________________________ Address:____

Please Send Consultation Report To:____

*I HAVE RECEIVED A COPY OF THE PRIVACY POLICY OF VITAL ALLERGY & ASTHMA CENTER AND HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICAL FACILITY, OR IT'S REPRESENTATIVE, TO RELEASE ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTION, OR TREATMENT AND COPIES OF ALL MEDICAL RECORDS TO VITAL ALLERGY & ASTHMA CENTER, PA. I ALSO AUTHORIZE VITAL ALLERGY & ASTHMA CENTER, PA, ITS PHYSICIANS AND PROVIDERS TO RELEASE MEDICAL RECORDS TO THE INSURANCE COMPANY THAT IS RESPONSIBLE FOR MY HEALTH COVERAGE SHOULD IT BE NECESSARY FOR PAYMENT OF SERVICES PROVIDED. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Signature:____ Date:________________________________

*THIS AUTORIZATION IS GOOD FOR ONE YEAR FROM DATE OF SIGNATURE

I HEREBY ASSIGN BENEFITS AND AUTHORIZE PAYMENT TO GO DIRECTLY TO VITAL ALLERGY & ASTHMA CENTER, PA FOR ANY MEDICAL SERVICE PROVIDED, BUT NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGE FOR THESE SERVICES. I AGREE THAT THE DOCTOR MAY RECEIPT FOR ANY SUCH PAYMENT AND THAT THIS RECEIPT SHALL BE A CONCLUSIVE ACKNOWLEDGEMENT BY ME THAT I HAVE RECEIVED BENEFITS FROM THE INSURANCE COMPANY ALL THE SUM SPECIFIED IN SUCH RECEIPT AND AGREE THAT SUCH PAYMENT SHALL DISCHARGE THE SAID INSURANCE COMPANY OF ANY AND ALL OBLIGATIONS UNDER THE POLICY TO THE EXTENT OF SUCH PAYMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTOR FOR ALL CHARGES NOT COVERED BY THIS AGREEMENT.

Signature:____ Date:________________________________

*THIS AUTHORIZATION IS GOOD FOR ONE YEAR FROM DATE OF SIGNATURE

Created 1/2009

FINANCIAL POLICY

Patient Name:
Medical Record No.:

FINANCIAL RESPONSIBILITY

All professional and diagnostic services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with the Central Business Office. As a courtesy, Vital Allergy and Asthma Center will file claims on an assigned basis, and resulting payments will be applied to the patient's account. By signing this form you acknowledge that you are responsible for any co-payment, coinsurance, or deductible amount determined by your insurance carrier or the full payment of services, if you do not have insurance coverage. If you do not wish to assign benefits and prefer to file your own claims, payment, of our standard fees for all serviced rendered will be due at the time of service, and upon request, you will receive the necessary statement from the practice to file your own claims.

STATEMENT OF ASSIGNMENT OF BENEFITS

By my signature below, I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plan, to issue payment(s) /check(s) directly to Vital Allergy and Asthma Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I acknowledge that I am responsible for any amount not covered by my insurance carrier.

This assignment will remain in effect for a period of one year from the date this assignment is granted, unless revoked in writing.

STATEMENT OF AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Vital Allergy and Asthma Center to: 1.) release any information necessary to insurance carriers regarding my illness and treatments; 2.) to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by either party in writing.

I have requested medical services from Vital Allergy and Asthma Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charged incurred in the course of treatment authorized.

I further understand that the fees I am responsible for are due and payable on the date that services are rendered, and I agree to pay all patient responsible portion(s) of the charges incurred immediately upon presentation of the statement. A photocopy of this assignment is to be considered as valid as the original.

____ ______________________________
Patient/Responsible Party Signature Date

CONSENT TO RELEASE INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS

Patient Name:
Medical Records No.:

With the increased awareness of a patient's right to confidentiality, we are asking all our patients to complete this form. This form will give the physicians and our office staff guidance as to who should be allowed to receive information about your healthcare.

Please complete one of the options listed:

1. [ ] DO NOT DISCUSS MY MEDICAL CONDITION WITH ANYONE
   If you choose this option, STOP HERE. Sign and date at the bottom.

2. [ ] NO RESTRICTIONS – DISCUSS MY MEDICAL CONDITION WITH ANYONE
   If you choose this option, STOP HERE. Sign and date at the bottom.

3. [ ] I, ____________________________, GIVE THE PHYSICIANS AND OFFICE STAFF OF CARLOS J. VITAL, MD, PERMISSION TO DISCUSS MY MEDICAL CONDITION WITH THE FOLLOWING INDIVIDUALS:

____
Name

________________________ ________________________
Relationship Phone

____
Name

________________________ ________________________
Relationship Phone

Please include on a separate piece of paper any other special instructions or limitations.

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted diseases (STDs); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of Vital Allergy and Asthma Center's Notice of Privacy Practices and any changed thereto which may be associated with this authorization. I have been provided an opportunity to discuss concerns I may have about the use or misuse of my health information with Vital Allergy and Asthma Center's privacy official or other appropriate personnel.

I understand that Vital Allergy and Asthma Center assumed no responsibility for the use or misuse by other of my health information disclosed under this content. I release Vital Allergy and Asthma Center and its agents and employees from all legal liability that may arise from this consent.

THIS CONSENT IS ACTIVE UNLESS YOU FILL IN AN EXPIRATION DATE OR YOU REVOKE THIS CONSENT IN WRITING.

______________________________________ ______________________
Patient Signature Date

____
Consent Expiration Date (if any)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Vital Allergy & Asthma Center

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:____

Relationship to Patient:______________________________________

Signature:____

Date:____