

Patient Information

Patient's last name _____ First _____ MI _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Work _____ Mobile _____
Email _____
Date of Birth _____ Gender (at birth) Male ___ Female ___
Marital Status: Single Married Divorced Separated Employer _____
Emergency contact _____ Phone _____
Primary Physician _____ PCP Phone _____
Referring Physician _____ Ref Dr. Phone _____

Responsible Party (minor patient):

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Work _____ Mobile _____
Date of birth _____

Insurance information

Primary _____ ID _____ Group# _____
Policyholder _____ Date of birth _____
Relationship to patient _____ Effective dates _____
Secondary _____ ID _____ Group# _____
Policyholder _____ Date of birth _____
Relationship to patient _____ Effective dates _____

Initial Below

____ I hereby authorize the physicians and representatives of Allergy and Asthma Specialists of Greater Washington to furnish medical treatment and provide information concerning my visits to my insurance carrier. I direct the insurer to pay all funds to Allergy and Asthma Specialists of Greater Washington directly.

____ I am aware that **I am personally responsible for all charges incurred during treatment whether covered by insurance or not.**

Co-payments and deductibles are due at the time of service

____ Patient or guarantor is responsible for all collection fees and costs for the collection of delinquent accounts.

HMO patients are responsible for securing and managing referral forms for their services.

____ I am aware that it is **my responsibility to inform AASGW of any changes, cancelations, or new insurance policies.**

Your signature below signifies your consent for treatment as well as your understanding of this payment policy.

Signature of patient or responsible party

Date

Allergy and Asthma Specialists of Greater Washington
A NOTICE TO OUR PATIENTS REGARDING OUR OFFICE POLICY

To keep our patients informed and to ensure proper reimbursement for services rendered, we ask that you carefully read the following instructions. By working closely together toward this goal we can provide you with better care and to avoid confusion in the future.

Insurance Coverage: We currently participate with several health plans. This does change periodically. Therefore, you may wish to inquire as to our participation with your plan. By signing the necessary forms at the time of your registration we can file your insurance claims for you.

Initial Below:

_____ I understand that I will be asked to show my insurance card at each visit as proof of coverage.

Initials each statement below:

_____ Please be aware that as medical providers, our relationship is with you and not your insurance company. Problems relating to your coverage should be handled between you and your carrier. HMO patients are responsible for securing and managing their referral forms for their services.

Payment Policy:

_____ It is the patient's responsibility to be informed as to your insurance coverage. We cannot adjust charges or diagnosis codes after services are rendered. If your insurance carrier denies payment, it is our policy that these amounts are to be paid within 60 days. We will bill you for charges allowed, but not paid, by your insurance plan.

_____ Copays and allowable deductible charges per your insurance are required at the time of your visit. Otherwise, you will need to reschedule your appointment. If you do not have insurance coverage, charges must be paid in full at the time services are rendered.

_____ Unacknowledged invoices over 90 days old will be forwarded to our collection's agency for further collection efforts. Accounts over 90 days that are over \$500.00 may be turned over to an attorney for legal action. Charges associated with these actions will be the responsibility of the patient.

Lab/Radiology Results:

_____ These results will only be discussed during an office visit. It generally takes 7-10 days for results to arrive from other facilities. You can assume your results will be available on your follow up appointment. Occasionally results do not make it to our facility, please have the name and phone number of the facility available on your next visit. You may contact our office before your appointment to ensure the results have arrived.

Cancellations:

_____ We require a 24-hour notice for cancellations. A fee of \$35 will be assessed for appointments not kept and notification not provided. This fee is not reimbursable by insurance.

Prescription Refills:

_____ We require at least 72 business hours for prescription refills. Please contact your pharmacy first to confirm there are no remaining refills. Then contact the office nurses' lines to initiate the refill request.

Medications and/or procedures requiring prior authorizations:

_____ These requests can take 3 to 10 business days to receive approval, if you have not received an update after this timeframe, please contact the office.

Emergency Phone Calls: We ask that only emergency phone calls be placed to our "on-call" providers. Please do not call for any prescription requests, including antibiotics, after office hours.

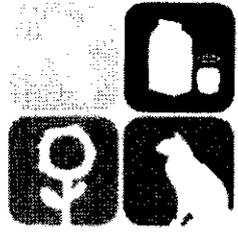
Forms and Letters:

_____ All forms and letters requiring authorization for administration of medications will be completed at your scheduled office visit. Requests after office visits can take up to one week for completion. Please note an up-to-date appointment is required to complete these forms including but is not limited to, schools, athletics, daycare, and camp letters and forms. Please play accordingly as these appointments prior to school.

PATIENT NAME

PATIENT SIGNATURE

DATE



Allergy & Asthma Specialists of Greater Washington

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Jyothi Gadde, M.D., P.A. Allergy & Asthma Specialists of Greater Washington, to use and disclose protected health information about me to carry out treatment, payment, and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jyothi Garde, M.D., P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Jyothi Gadde, M.D., PA, 400-C Hospital Drive. Warrenton, VA 20186.

With this consent, Jyothi Gadde, M.D., P.A. and members of the staff may call my home or other alternative location and leave a message on voice mail (see authorization) through patient portal or in person in reference to any items that assist the practice in carrying out TPO, such as, appointment reminders, insurance items and any calls pertaining to my clinical care, including prescriptions, treatment, among others. As specified on the Patient Contact Authorization.

With this consent, Jyothi Gadde, MD. P.A. may mail to my home, patient portal, email or other alternate location, any items that assist the practice in carrying out TPO.

However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement. By signing this form, I am consenting to Jyothi Gadde, M.D., PA's (AASGW) use and disclosure of my PIII to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jyothi Gadde, M.D., P.A. may decline to provide treatment to me.

Patient's name (please print)

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date

Patient Contact Authorization

Patient name _____ Date of Birth _____

To reach you more efficiently to confirm appointments, leave messages regarding your healthcare and to discuss insurance billing issues, we are asking you to complete the following telephone contact information.

Please complete the below contact information:

Cell Phone: _____ ok to leave a message: YES NO

Work Phone: _____ ok to leave a message: YES NO

Home Phone: _____ ok to leave a message: YES NO

Messages may be sent through patient portal using the email below: YES NO

Email: _____

(also used for patient portal)

Emergency Contacts: Please list (at least one) name (s) of family or friend(s) with whom you authorize us to contact relating to your medical care.

1. _____ Relationship _____

2. _____ Relationship _____

Please list the name and telephone number of your pharmacy.

Pharmacy: _____ Street _____

Phone: _____

By signing below, I authorize my physician or their representatives to contact me about my appointments, billing issues, prescriptions or the individuals listed above in the event I am not available.

Signature: _____ Date: _____