Allergy & Asthma Associates *of the Bluegrass*
*171 N. Eagle Creek Drive, suite 106 * Lexington, KY 40509*

I acknowledge that Allergy & Asthma Associates of the Bluegrass has made available to me a copy of its ***Notice of Privacy Practices*** *which is located in the waiting room. It provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.*

_____ _____
Signature of Patient or Representative *Date*

_____ _____
Name of Patient or Representative *Relationship to Patient*

Allergy & Asthma Associates
of the Bluegrass
Allergy & Asthma Associates, P.S.C.

PATIENT INFORMATION

First name_____Middle name_____Last name_____

Birth Date_____Age_____Sex_____Preferred Name_____ Is patient a minor? **YES** **NO**

Address _____City/State_____Zip _____

Phone ( )_____Social Security # _____ Marital Status: **M** **S** **D** **W**

Employer _____Employer Address_____

Employer Phone # ( )_____Parents/Spouse names_____

HAVE YOU/FAMILY MEMBER BEEN SEEN BY OUR DOCTORS? YES NO Name_____

IF PATIENT IS A MINOR PLEASE COMPLETE GUARANTOR INFORMATION

PARENT/GUARANTOR ACCOMPANYING CHILD _____RELATIONSHIP_____

Address_____ Social Security #_____ Birth Date_____

Employer_____ Employer Address_____

Work Phone ( )_____Spouse's name_____Birth Date_____

May we have your E-mail address? _____(Will *NOT* be shared with anyone outside this office)

MEDICAL INSURANCE INFORMATION

Name of Primary Insurance _____ID # _____

Group #_____Who is the policy holder?_____Birthdate_____

Name of Secondary Insurance _____ID #_____

Group #_____Who is the policy holder?_____Birthdate_____

EMERGENCY CONTACT:_____Phone #( )_____Relation to patient_____

PRIMARY PHYSICIAN_____ **Phone # ( )**_____

Address _____

REFERRING PHYSICIAN_____ **Phone # ( )**_____

Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____(name of insurance) and assign directly to Allergy & Asthma Assoc., P.S.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

CONTINUED ON BACK

Allergy & Asthma Associates
of the Bluegrass

Kenneth L. Gerson, M.D. **William A. Greisner, III, M.D.**

I understand that it is my responsibility to obtain a current referral from my primary care physician, if a referral to a specialist is required by my insurance company.

I also understand that if I do not obtain a referral for today's office visit and testing, **I will be responsible for payment for these services.** I agree to maintain a current referral for future services, such as injections and allergy serum vials, and understand **I will be responsible for payment** if referral is not kept current.

I understand that if my insurance does not pay in a timely manner or denies payment for any reason, **I will be responsible for the balance on my account, as well as a 35% collection fee if balance is not paid in a timely manner.**

Please note: it has been our experience that some insurance companies also charge a percentage co-pay for testing in addition to an office visit co-pay.

I agree to pay my co-pay at time of service, and any co-pay thereafter as required by my insurance company for testing or other services rendered.

_____ _____

Signature of patient or legal guardian Name of patient

_____

Date

Allergy & Asthma Associates
of the Bluegrass

Kenneth L. Gerson, M.D.
Amy B. Mashburn, M.D.

William A. Greisner, III, M.D.
Elizabeth K. Mentzer, PA-C

CANCELLATION/NO-SHOW POLICIES

The no-show/cancellation policy is enforced for the following reasons:

1. We rely heavily on our schedule to maintain a high standard of care.
2. By giving appropriate notice to our office, we are able to offer your appointment time to other patients.
3. Cancellations are likely to prevent you from experiencing optimal outcomes from treatment.

NO-SHOW POLICY

If you do not cancel your appointment by 24 hours prior to your scheduled appointment, a $25 no-show fee will be charged to your account. The fee may be waived for an emergency and if rescheduled.

REPEATED CANCELLATIONS

Optimal outcomes from treatment can only be achieved if you take responsibility in your care and are compliant with the recommendations. Repeated cancellations may result in you being discharged for noncompliance.

These policies are strictly enforced to assure you receive the care you deserve and achieve your goal. We pride ourselves in providing the highest quality of care possible. Please help us maintain this level of care by making your time here a priority.

_____ _____

Patient's Name Date

_____

Patient/Responsible Party Signature