Allergy Affiliates, Michael Y. Viksman, M.D., LLC

In order to serve you properly, we will need the following information. Please fill out completely: Please Print

Patient Name: _____ Age: _____ Birthdate: _____ (M) (F)

Address: _____ City: _____ State _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Soc. Sec. #: _____ Driver's License: State: _____ Number: _____

Email Address _____ **Preferred language** _____

Race _____ **Ethnicity** ☐ Hispanic ☐ Not Hispanic ☐ I prefer not to answer

Employer: _____ Address: _____ Phone: _____

Primary Physician: _____ Physician's Address: _____

Phone: _____ Pharmacy: _____ Pharmacy Phone: _____

Referred by: _____

Emergency Contact _____ Relationship _____ Phone _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR

Name: _____ Relation to patient _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employed by: _____ Employer Phone: _____

Driver's License #: State: _____ Number: _____

INSURANCE INFORMATION

Primary Insurance Company: Name of Insurance Company: _____

Address: _____ City: _____ State _____ Zip: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Relation to Patient: _____ (M) (F)

Date of Birth: _____ SS# _____

Policy #: _____ Group # _____

Office visit covered? Yes No Referral Needed? Yes No CoPay Amt _____

Secondary Insurance Company: Name of Company: _____

Address: _____ City: _____ State _____ Zip _____

Employer: _____ Address: _____ City _____ State ___ Zip _____

Policy Holder: _____ Relation to Patient: _____ (M) (F)

Date of Birth: _____ SS#: _____

Policy #: _____ Group # _____

Office visit covered? Yes No **Referral needed? Yes No** **CoPay Amt** _____

The information above is, to the best of my knowledge, accurate and current. I understand that I am financially responsible for all the charges whether or not paid by insurance. I am responsible for immediately informing the office of any charges in insurance coverage, and I will bear financial responsibility for lack of payment due to inaccurate information. _____ ((initials)

If my insurance requires referrals, I understand that I am responsible for obtaining the correct referral forms from my primary care physician. It is also my responsibility to keep them current. I accept financial responsibility for any service not paid due to lack of a referral. _____ (initials)

CONSENT FOR ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Allergy Affiliates, Michael Y. Viksman, M.D., LLC for services provided. I authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided for the purpose of evaluating and administering claims of benefits

Signature _____ Date _____

CONSENT TO TREAT

I, the undersigned as "patient" of being a person legally authorized to consent to services on behalf of the "patient" consent and authorize Allergy Affiliates, Michael Y. Viksman, M.D., LLC. to administer any treatment which may be deemed medically necessary for diagnosis and treatment.

Signature _____ Date _____

PAYMENT POLICIES

Copays are due at the time of service. Any copay that has to be billed will incur a $5.00 billing charge on each outstanding copay, each billing cycle.

Returned checks are subject to a $20,00 service fee. Checks will not be redeposited.

Signature of responsible party: Date: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION AND TREATMENT

Please list the person(s) to whom we may release medical information

_____

Please list any person who may bring your child for treatment _____

I understand we may revoke this consent in writing at any time.

Signature _____ Date _____

Relationship to Patient _____

NO SHOW AND CANCELLATION FEE

A 24-hour cancellation notice is required for all appointments. A $25 fee will be implemented if required notice is not given.

Signature _____ Date _____

Allergy Affiliates, Michael Y. Viksman, M.D., LLC

In order to serve you properly, we will need the following information. Please fill out completely: Please Print

Patient Name: _____ Age: _____ Birthdate: _____ (M) (F)

Address: _____ City: _____ State _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Soc. Sec. #: _____ Driver's License: State: _____ Number: _____

Email Address _____ **Preferred language** _____

Race _____ **Ethnicity** ☐ Hispanic ☐ Not Hispanic ☐ I prefer not to answer

Employer: _____ Address: _____ Phone: _____

Primary Physician: _____ Physician's Address: _____

Phone: _____ Pharmacy: _____ Pharmacy Phone: _____

Referred by: _____

Emergency Contact _____ Relationship _____ Phone _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR

Name: _____ Relation to patient _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employed by: _____ Employer Phone: _____

Driver's License #: State: _____ Number: _____

INSURANCE INFORMATION

Primary Insurance Company: Name of Insurance Company: _____

Address: _____ City: _____ State _____ Zip: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Relation to Patient: _____ (M) (F)

Date of Birth: _____ SS# _____

Policy #: _____ Group # _____

Office visit covered? Yes No Referral Needed? Yes No CoPay Amt _____

Secondary Insurance Company: Name of Company: _____

Address: _____ City: _____ State _____ Zip _____

Employer: _____ Address: _____ City _____ State ___ Zip _____

Policy Holder: _____ Relation to Patient: _____ (M) (F)

Date of Birth: _____ SS#: _____

Policy #: _____ Group # _____

Office visit covered? Yes No **Referral needed? Yes No** **CoPay Amt** _____

Allergy Affiliates

Michael Y. Viksman, M.D., LLC

Payment Policy

Thank You for choosing the Allergy & Asthma Group. We are committed to providing you with quality and affordable healthcare. This policy is to help answer questions regarding patients and insurance responsibility for services rendered. Please read it, ask any questions you may have and sign the bottom. A copy will be provided to you upon request.

1. **Insurance-** We participate with most plans including Medicare. If you are insured with a plan we are not contracted with payment is expected at each visit. Please contact your insurance company with questions you have regarding your coverage.
2. **Copayments and deductibles-** all copays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **Non Covered Service-** Please be aware that some of the services you receive may be a non-covered service. You must pay for these services at the time of service or within the 30 day billing cycle.
4. **Proof of Insurance-** All patients must complete our patient registration form before seeing the doctor and provide a copy of their current insurance card.
5. **Claim submission-**We will submit your claims and assist you in any way we reasonably can to get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage Changes-**If your insurance changes it is your responsibility to notify us before your next visit so we can make the appropriate changes.
7. **Nonpayment-** If your account is over 90 days past due you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if your balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the practice.
8. **Missed Appointment-** Our policy is to charge a fee for a missed appointment not canceled within 24 hour of the appointment time. Please help us to serve you better by keeping your scheduled appointments.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Allergy Affiliates, Michael Y. Viksman, M.D., LLC
368 Lakehurst Rd.
Toms River, NJ 08755

Notice of Privacy Practices Acknowledgement

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:

- Treatment
- Obtain payment from third-party payer.
- Conduct normal healthcare operations

I have received, read and understand 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. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: