***** PLEASE RETURN AS *****
***** SOON AS POSSIBLE *****

PHYSICIAN:
- ☐ Eddie W. Shields, M.D.
- ☐ Lori M. Kagy, M.D.
- ☐ Kelly D. Burks, M.D.
- ☐ Nancy W. Zuerlein, M.D.
- ☐ Lindsay Still, MD

AAAC
ARKANSAS
ALLERGY AND ASTHMA CLINIC
A TRADITION OF QUALITY PATIENT CARE SINCE 1930

FOR OFFICE USE ONLY:
Patient #: _____
APPOINTMENT:
Day: _____
Date: _____
Time: _____
CLINIC:
☐ Little Rock ☐ Conway

NEW PATIENT PRE-REGISTRATION FORM

PATIENT INFORMATION:

Name: _____
Last First Middle

Patient's Social Security No.: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone (Area Code): _____

Cell Phone (Area Code): _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Email Address: _____

REFERRING PHYSICIAN:

Name of physician that recommended you see an allergy/asthma specialist for evaluation. ☐ NONE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

ACTIVE INSURANCE INFORMATION:
Primary Insurance Carrier

Name: _____

Policyholder's Name: _____ D.O.B.: _____

Secondary Insurance Carrier, if applicable:

Name: _____

Policyholder's Name: _____ D.O.B.: _____

PATIENT EMPLOYER:

Employer: _____ Phone #: _____

SPOUSE:

Name of Spouse: _____

Date of Birth: _____

Spouse's Social Security No.: _____

Spouse's Employer: _____

IF PATIENT IS A MINOR:

Father's Name: _____ D.O.B.: _____

Father's Employer: _____

Father's Social Security No.: _____

Cell Phone (Area Code): _____ Email: _____

Mother's Name: _____ D.O.B.: _____

Mother's Employer: _____

Mother's Social Security No.: _____

Cell Phone (Area Code): _____ Email: _____

EMERGENCY CONTACT (not living in same household):

Name: _____

Phone (Area Code): _____

Date of Birth: _____

Relationship to patient: _____

RACE: ☐ White/Caucasian ☐ Black/African American ☐ Hispanic ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race: _____

PHARMACY:

Local Pharmacy: _____

Location: _____

Arkansas Allergy & Asthma Clinic, P.A.

Kelly Burks, M.D. ● Lori Kagy, M.D. ● Eddie Shields, M.D. ● Nancy Zuerlein M.D ● Lindsay Still, MD

FINANCIAL POLICY

Your understanding of our financial policy is an important part of your care and our professional relationship. Please ask if you have any questions regarding our fees, policies, or your financial responsibility.

Full payment for office visit charges is due at the time of service. We accept cash, check, money order or credit card. Should you need to make payment arrangements, please contact our Patient Accounts Specialist before your scheduled appointment.

INSURANCE

AAAC files claims with all commercial insurance companies (example: Blue Cross Blue Shield, Medicare, Medicaid, HMO's and PPO's). **Any co-pays, deductibles, co-insurance payments, or non-covered services are your responsibility and are due at the time of service.**

If your insurance requires a referral, you are responsible for making sure a referral is obtained by the date of service. If our office does not have a referral at the time of service and your insurance does not pay, you will be responsible for the charges for services rendered.

SELF-PAY

For patients without insurance we allow a 25% discount on our fees for full payment at the time of service. Please make sure to let the cashier know that you would like to take advantage of this discount.

PAYMENT OPTIONS

Under certain circumstances, a statement may be mailed to you. All charges billed are due within 14 days of receipt of the statement. You are directly responsible for any unpaid balance on your account. If payment cannot be made when due, you must contact our Patient Accounts Specialist to set up an extended payment arrangement.

AAAC offers the option to pre-authorize your post-visit balances. We will estimate your balance and authorize your payment card for that amount. When your insurance has been adjudicated, we will then process a charge to your card for the balance, not exceeding what you have authorized. This automated process eliminates the need for us to bill you for future payment.

After 30 days, if no payments or extended payment arrangements have been made, necessary collection efforts will begin.

In divorce cases, regardless of who has been awarded custody or financial responsibility for the child, the person bringing the child for treatment is responsible for payment of services rendered.

AAAC is committed to providing you and your family with the best medical care. Our charges reflect the usual and customary fees for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of benefits.

NO SHOW FEE

Failure to keep an appointment at the scheduled time, along with failure to notify AAAC of cancellation at least 24 hours prior to the scheduled appointment time, will result in a $35.00 no show fee assessed to the patient account.

I have read the Financial Policy of Arkansas Allergy & Asthma Clinic P.A. I understand that I am financially responsible for all charges whether or not covered by insurance. By my signature below I acknowledge that I have received a copy of the Arkansas Allergy & Asthma Clinic P.A. Financial Policy.

_____ _____

Patient or Patient Representative Date

Arkansas Allergy & Asthma Clinic, P.A.

Kelly Burks, M.D. ● Lori Kagy, M.D. ● Eddie Shields, M.D. ● Nancy Zuerlein, M.D ●Lindsay Still, MD

Receipt of Notice of Privacy Policies & Consent Form

Patient: _____ DOB: _____

In the course of providing services to you, we create, receive and store protected health information (PHI) that identifies you. It is often necessary to use and disclose this PHI in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* (NOPP) you have been given describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this form. As described in our NOPP, the use and disclosure of your PHI for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your PHI for purposes of payment includes (1) our submission of your PHI to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your PHI to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our NOPP. Our NOPP will be updated whenever our privacy practices change. You can obtain an updated copy of the NOPP in our office.

When you sign this consent document, you signify that you agree that we can/will use and disclose your PHI to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices.*

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or other healthcare operations, but as described in our NOPP, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our NOPP describes how to ask for a restriction.

Patients in our practice may be contacted via email, cell phone and/or text messaging to remind you of an appointment, provide healthcare reminders/information and for patient account information. If at any time you provide an email, cell phone number or text address at which you may be contacted, you consent to receiving the message types described above from this practice.

_____ (Patient Initials) I consent to receive calls and/or text messages from this practice at my cell phone and any other number forwarded or transferred to that number, or emails, to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders, healthcare communications/information, and patient account information unless I request a change in writing.

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request healthcare and/or financial information. Under the requirements for HIPPA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your healthcare and/or financial information released to any family members, you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Arkansas Allergy & Asthma Clinic, P.A. to release my healthcare and/or financial information to the following individuals:

1) _____ Relationship: _____
2) _____ Relationship: _____
3) _____ Relationship: _____

I have read the NOPP of this office and understand it. I consent to the use and disclosure of my PHI for purposes of treatment, payment and healthcare operations.

_____ Date: _____
Patient Signature

If signing as a personal representative of this patient, describe the relationship to the patient:

_____ _____
Print Name Relationship to Patient