I N D I A N A
ALLERGY & ASTHMA

Pooja Oza Patel, MD
9012 Connecticut St, Merrillville, IN 46410
Phone: (219) 769 - 6177
www.IndianaAllergy.com

DEMOGRAPHIC INFORMATION

Patient Name: Date of Birth

Address City Zip

Cell phone Social Security #

Email Address

Responsible Party (if different than above) Date of Birth

Relationship Social Security #

Address: City Zip

Cell Phone:

Insurance Name ID # Group #

Member Name (if different than above) Address

Social Security # Relationship to Patient

Date of Birth Employer

Emergency Contact Relationship

Phone

How did you hear about us?

Referring Physician's Name and Number

List of allergies:

List of medications:

I have read all the information on this page and completed the above information. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I authorize the release of any medical information needed to determine the benefits payable for services rendered by Dr. Pooja Oza Patel at Indiana Allergy And Asthma LLC .

Patient Signature_____ Date

If Patient is a minor, Parent/Guardian Signature _____ Date

<u>Appointment and Financial Policy</u> (Originally effective: 7/1/2021)

Thank you for choosing us for your Asthma, Allergy and Immunology healthcare needs. We are committed to providing you with the best medical care. The following is a statement of our appointment and financial policies which we require you to read and sign prior to your treatment.

Your Responsibility: It is your responsibility to provide us with accurate information so that we can file your claims correctly, including copies of your insurance card(s) and photo identification. If your address, telephone number, or insurance changes, please notify us immediately. If your insurance changes it is your responsibility to verify that we are contracted with your new plan.

Referrals and Authorizations: Some insurance plans require your primary care provider to obtain a referral authorization number from the insurance company in order for you to see us. A referral requirement is the result of your contract with your insurance company, so it is ultimately your responsibility to ensure that it has been done prior to your visit. If your insurance company denies payment because a referral has not been obtained, you will be responsible for the cost of the visit. You are responsible for any balances classified as 'Patient Responsibility' by your insurance company. Any dispute with claim processing is between you and your insurance company.

Insurance Policy: We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

Financial Arrangements for Payment and Fees: Once your insurance processes your claim, a copy of the EOB (Explanation of Benefits) will be issued to you by your insurance company. We will send a statement for balance due based off of your finalized claim. Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, you may pay in person or by mail, or allow the balance to be charged to your credit card on file. We accept all major credit cards, debit cards, personal checks and cash for payment. Credit cards on file will be used to pay copayments which are due on the date of service, and any remaining balance owed by you 30 days after your insurance processes your claim If payments are declined or a credit card is expired at the time of payment, we will call you. If the reminder call is not returned within one week, a $35 collection fee will be applied to your account. Returned checks will be subject to a $35 returned check fee. If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment. All accounts over 60 days without an approved payment plan are subject to a finance charge of 15% APR. Past due account balances must be settled before being seen for subsequent appointments, and future appointments may not be scheduled until a valid and currently valid credit card is on file. In the event I fail to pay the balance of my account to Indiana Allergy And Asthma LLC of sixty (60) days of the date of service, my account will be turned to collections. In the event that it is necessary to turn my account over to collection, I will also be responsible for any and all costs of collection, including attorney fees and interest charges.

Appointment Policy: We gladly reserve appointment times for you and appreciate that you have chosen Indiana Allergy and Asthma for your care. As a courtesy, we will remind you of your appointment by calling and/or text/emailing you prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patients' valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge $25 for regular appointments cancelled or missed without advance notice of 2 business days prior to the appointment, We charge a $50 fee for cancelled or missed appointments for new patients, allergy testing, food or drug challenge without providing us notice 3 business days prior to the appointment. These fees must be paid in full before any new appointments will be scheduled or medications refilled. If you arrive at your appointment late, we will do our best to work you back into the schedule; however, you may be asked to wait or to reschedule.

Forms: Due to the tremendous volume of patient forms requested on a regular basis, we kindly request that required forms or unscripted letters for school or work (ie. Action Plans for Food Allergy, Asthma, Medication forms for school, etc.) are completed during your medical appointment. There is no charge for these required forms if completed during a visit.
If forms or unscripted letters required for school or work are requested to be completed at a time not concurrent with a visit, we reserve the right to charge $25 for their completion.

For completion of forms that are of much greater length and take considerable time of medical records review (i.e., Disability forms, FMLA requests, EFMP requests, etc.), we reserve the right to charge $50 for their completion.

Patient Parent or Guardian Responsibility: The parent or guardian who accompanies a child to their Allergy Immunology appointment has authorization to consent to medical care as needed and is responsible for payment of medical services. It is the parent or guardian's responsibility for payment of all Allergy Immunology services provided by Indiana Allergy And Asthma LLC in accordance with the practice's fees and terms. In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.
All children under the age of 18 years must be accompanied by a parent or guardian to all visits where testing will be performed or for allergen immunotherapy (allergy shots). At the initial visit, a parent or guardian may sign our consent allowing us to render care to their children under the age of 18 years for follow up visits only without the presence of a parent or guardian.

Assignment and Release: I authorize payment to be made directly to Indiana Allergy And Asthma LLC by my insurance company, and I accept financial responsibility for all services not covered by my insurance. Copayments, deductibles, coinsurances and self-pay payments are due at the time of service and no exceptions will be made. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Credit Card on File Policy: Indiana Allergy And Asthma LLC is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. You will be asked to provide or verify your credit card number at the time you check in for your visit. Your credit card will be scanned with a card reader. Your credit card number will be stored in a secure, compliant location in your electronic medical record. For security reasons only the last four digits will be visible to our staff. Credit cards on file will be used to pay copayments which are due on the date you are seen in our office, and any remaining balance owed by you 30 days after your insurance processes your claim. If payments are declined or a credit card is expired at the time of payment, we will call you. If the reminder call is not returned within one week, a $35 declined payment fee will be applied. Additional appointments will not be scheduled until a valid and currently valid credit card is on file. I give Indiana Allergy And Asthma LLC permission to charge my credit card for any patient balance due on my account, including fees noted in this document (inclusive of late cancellation, missed appointments, returned checks, declined credit card payment, fees for forms, or finance charges). If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

Acknowledgement of Financial Policy:I have read a copy of Appointment and Financial Policy provided by Indiana Allergy And Asthma LLC and I agree to abide by these policies. I am also aware that I may obtain a copy of the Patient Financial Agreement form at any time as reference. Should it become necessary for Indiana Allergy And Asthma LLC to turn my account over to a collection agency or attorney, I (We) understand that I (We) will also be responsible for any costs of collection, including attorney fees. I understand that this authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this day forward until it has been revoked in writing.

Name of Patient : _____ **Date:** _____

Signature of Responsible Party (Guarantor): _____
Note: The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.

HIPAA and Patient Consent

Full Name: _____ Date of Birth _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. IIndiana Allergy And Asthma LLC is required by law to maintain the privacy and confidentiality of your protected health information and to provide patients with notice of our legal duties with respect to your protected health information.

Disclosure of your health care information

- **Treatment:** We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.
- **Payment:** We many disclose your health care information to your insurance care provider for the purpose of payment or health care operations.
- **Workers' Compensation:** We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
- **Emergencies:** We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency of your death.
- **Public Health:** As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
- **Judicial and Administrative Proceedings:** We may disclose your health information in the course of any administrative or judicial proceedings.
- **Law Enforcement:** We may disclose your health information to a law enforcement official for the purpose such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, or other law enforcement purposes.
- **Deceased Persons:** We may disclose your health information to organizations involved to coroner's medical examiners.
- **Organ Donation:** We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- **Research:** We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.
- **Public Safety:** It may be necessary to disclose your health information to the appropriate person in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- **Specialized Government Agencies:** We may disclose your health information for military, national security, prisoner and government benefit purposes.
- **Marketing:** We may contact you for marketing purposes or fund raising purposes.
- **Change of Ownership:** In the event that Indiana Allergy And Asthma LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Indiana Allergy And Asthma LLC is not required to agree to the restriction of your request.
- You have the right to have your health information received or communication through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Indiana Allergy And Asthma LLC amend your protected health information. Please be advised, however, Indiana Allergy And Asthma LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Indiana Allergy And Asthma LLC
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this notice of privacy practices: Indiana Allergy And Asthma LLC reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Indiana Allergy And Asthma LLC is required by law to comply with this notice.
Indiana Allergy And Asthma LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us.

Informed Patient Consent:

- I give my permission to Indiana Allergy and Asthma providers and staff to treat me, including any procedures, as deemed necessary in the exercise of their professional judgment.
- I understand medical care requires my cooperation, and I will follow my doctor's orders and prescription. If indicated, I will make and keep appointments for follow up care, and call the office to note any changes or concerns in my condition.
- I authorize my physician to release any information, including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such medical care, to third party payers including, Medicare and Medicaid.
- I authorize and request that my insurance company, in lieu of reimbursing me directly, pay the doctor or medical office any benefits for services rendered.
- I understand that my insurance company carrier may pay less than the actual bill for services; I agree that it is my responsibility to provide for payment of all services rendered on my behalf or my dependents.
- I will notify the office if/when there are pertinent changes to my medical history, including medical conditions and changes in insurance carriers. I will also notify the office of any changes in my contact information.

Questions or Concerns: If you would like to submit a question or concern about our practice's privacy practices, or obtain more information about your patient rights, you may do so by contacting our privacy officer

Genia Wilgus
9012 Connecticut St, Merrrillville, IN 46410
Phone: (219) 769 - 6177
Fax: (219) 769-1374

I have read the Privacy Notice and understand my rights contained in the notice. By way of signature, I provide Indiana Allergy And Asthma LLC with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

By signing below, I acknowledge that I have received a copy of the Notice or Privacy Practices. I understand that I may obtain a copy of this Notice at any time upon request.

Name of Patient: _____ Date of birth: _____

Patient / Parent / Guardian Signature: _____ Date: _____

Release of Medical Information

(HIPAA Privacy Authorization Form)

Name _____ Date of Birth _____

Please check one of the following options:

☐ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may only be released to the following individual(s):

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

☐ I do not authorize my information to be released to an individual(s).

Communication:

I authorize my doctor or staff to send me personal health information (PHI). As we try to ensure the safety of all PHI, no guarantee that the confidentiality or security of electronic transmission via the internet or cell phone can be made due to potential unsecured devices and links.

Phone (voice/text)	☐ Yes	☐ No
Email	☐ Yes	☐ No

This ***Release of Medical Information*** will remain in effect until terminated by me in writing.