Chacko Allergy- Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Payment is due at time of service. This is subject to include copay, coinsurance, deductible, and/or any non-covered service.
3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.
6. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv)amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement. This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.
12. Advanced Beneficiary Notice of Non-Covered or Under Covered (underpayment) of Service(s) Provided- I understand that the above services may be billed to my insurance any my insurance may not cover or may under cover the costs associated with the procedure(s). On the explanation of benefits received from the insurance company, even though there is an expected write off due to contractual obligations, this amount may not be written off due to the under payment for the service (s) and will be billed to the patient accordingly. I understand this process and approve the proposed services.

Patient Name:_____ DOB: _____

_____

Name as it Appears on Card/ACH Account

_____

Email Address Telephone No

_____

Billing Address City State Zip

COMMUNICATION WAIVER

I understand that as part of my healthcare, Chacko Allergy may need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information. I authorize the above to contact me in the following ways (please check those that you authorize):

___ Home phone ___ Email ___ Work phone ___ Cell phone

At times, Dr. Chacko and his team will communicate with other providers and/or the patients themselves via email or text. This form of communication is generally not HIPPA certified or encrypted but done as a means to expedite communication between patients and/or their providers. There will always be a link through the E-Clinical Works portal if you would prefer to communicate in that manner. Often, though, patients prefer to communicate through text or e-mail.

Do you allow consent for Dr. Chacko and his staff to communicate with you/your providers through non-HIPPA certified modes such as email or texting?

____ **Yes,** I do consent ___ **No**, I **do not** consent

EMERGENCY CONTACT: _____

TEL: _____ RELATION: _____

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize Chacko Allergy to request and receive the complete medical records in regards to my illness and/or treatment from:

_____

_____

_____

PATIENT NAME: _____DOB:_____

AUTHORIZED SIGNATURE: _____ DATE: _____

CHACKO ALLERGY

Roswell Office	Cumming Office	Johns Creek Office	Duluth Office
3333 Old Milton Pkwy Suite 520 A1pharetta, GA 30005	303 Pirkle Ferry Rd - Cumming, GA 30040	3905 JohnsCreek Crt. Suite 200 Suwanee, GA 30024	3855 Pleasant Hill Rd Suite 420 Duluth, GA 30096

ALLERGY, ASTHMA AND SINUS DOCTOR

PHONE: (678) 668- 4688
FAX: (888) 823 -1934

New Patient Questionnaire

Name: _____ Date of Birth: _____ Date: _____
Height:_____ Weight: _____ How did you find us: _____

Referring Physician: _____ PCP: _____
(If other than Primary Care Physician) (Primary Care Physician)

Preferred Pharmacy: _____
Reason for Visit: Circle All that apply

Hay Fever/Allergies	Food Allergy	Frequent Infections	Top Symptoms:
Nose/Sinus Problems	Reaction to Insect Sting	Sinus Infections	1._____
Asthma	Reaction to Medication	Rash or Itchy Skin	2._____
Difficulty Breathing	Other: _____		3._____
Swelling			

What brings you to see the allergist? _____
_____
_____

Patients 65 years and older: Have you received your pneumococcal vaccine? Yes __ No ___

Patients 6 months and older:
If applicable, has patient received influenza vaccination during current year flu season?
Yes___ No___ (Between October-March of current year)

Symptoms/Medical History:
If Hay fever symptoms, what season are they worse?
Spring Summer Winter Fall
What triggers your symptoms? (Dogs, Cats, Foods, or anything else) _____
_____
What allergy medications have you tried? _____
_____
Which (if any) have helped improve how you feel? _____
_____

If Asthma, have you ever been Hospitalized, ER, or Intubated for Asthma? Yes No N/A

Any other current Medical Problems? _____
_____
_____

Current Medications: _____

_____

_____

Allergies to any medications? _____

_____

_____

____No known drug allergies

Surgical History: _____

_____

_____

Have you previously seen an Allergist? Yes No

If so, when? _____

Have you ever been on Allergy Shots? Yes No

If yes, when? _____

Personal History:

Marital Status: Married Single Widowed Divorced

Number of Children in Household: _____ Years living in Atlanta? _____

Any pets in the house? No Yes What pets at home? _____ Occupation: _____

Social History:

Tobacco Use/Smoking: Yes No

If yes, current or former/ year quit? _____ Drug Abuse: Yes No

Review of Symptoms: Circle all that Apply

Congestion	Wheezing	Recurrent Sinus	Post Nasal Drip
Hives	Sinus/Pain Pressure	Infections	Anxiety
Abdominal Pain	Decreased Sense of	Eczema	Other: _____
Nausea	Smell	Coughing	_____

Family History: Do any members of your family have a history of the following?

	Yes	No		Yes	No
Asthma			Food Allergy		
Hay Fever			Other:		
Eczema			Other:		
Swelling/Hives			Other:		