FLATIRON ALLERGY & ASTHMA CENTER

For Office use Only: Ht: ____ Temp: _____ Pulse:____

Wt: ____ B/P:_______ Pulse Ox:____

Patient's Name: ______________________________ Pharmacy Name and Location: ______________________

Date of Birth: ________________________________ Primary Care MD: _________________________________

Today's Date: ________________________________ Referring MD: ____________________________________

Change in Address? YES/NO **Change in Insurance?** YES/NO

Can we leave a message about Lab Results: ___Yes ___No Reminder Email:______________________

Up to date on Flu Vaccine? No/Yes, Date: _______________ **Smoking**: ___Yes ___No ___Prior

Up to date on Pneumonia Vaccine? No/ Yes, Date: _______________ **Pregnancy**: ___Yes ___No

Reason for Visit: ____

Interim Health Events since last visit:

____

____

Allergy/Reaction to Medication:

____

____

Current Medications or BRING A CURRENT LIST:

Name	Dosage	Frequency

Review of Systems (PLEASE CIRCLE):

General/Constitutional: fatigue, fevers, headache, recent illness, weight gain or loss

Eyes: contact lenses/glasses, disease or injury, itchy, pain, redness, watering, vision change

Ear/Nose/Throat/Neck: frequent sinus infections, hearing loss, itchy nose, nasal stuffiness, bleeding, pain, post-nasal drip, ringing of ears, runny nose, sneezing, snoring, masses in thyroid

Cardiovascular: chest pain, heart murmurs, or hypertension

Respiratory: cough, respiratory infections, shortness of breath, or wheezing

Gastrointestinal: abdominal pain, constipation, diarrhea, difficulty with swallowing, indigestion/heartburn, nausea, or vomiting

Genitourinary: frequency, infections, or urgency

Musculoskeletal: limitation of motion, pain, swelling

Skin: dryness, eczema, hives, itching, or rash

Neurologic/Psychiatric: anxiety, depression, or seizures

Endocrine: diabetes, glandular problem/thyroid disorder, or intolerance to heat/cold

Hematologic: anemia, bleeding tendency, or previous transfusion and reactions

Allergic/Immunologic: frequent infections, reactions to: foods/insects/medications/vaccines

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FINANCIAL POLICIES

Please understand that Flatiron Allergy and Asthma Center's (FAAC) financial policies are established to ensure the financial resources needed to maintain this medical office for all our patients. We must emphasize that as a health care provider our relationship is with you and not your insurance company.

It is your responsibility to inform our office of any patient information changes including name, address, and insurance information.

Please read and sign the following financial policies indicating your understanding of these policies and accepting financial responsibility for all services provided. Please ask us if you have any questions about our fees, policies, or your responsibilities.

Insurance

- The patient is required to present an insurance card at each visit. It is the patient's responsibility to make sure that all insurance information given to our office is correct and current, including both primary and secondary insurance. Failure to provide us with correct insurance information could result in your insurance company rejecting your claims for failure to obtain authorization, timely filing or other reasons and may result in your responsibility for the entire bill.

- FAAC will bill your insurance company. It is your responsibility to verify your coverage and adhere to the restrictions of your plan. Your insurance is a contract between you, your employer if applicable, and your insurance company. Please contact your insurance company and/or your employer's human resource department with regards to your benefit questions. Although we may estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility and benefits.

- You may be responsible for charges incurred in this office that are not paid by your insurance company, including those applied to your deductible or coinsurance, in accordance with FAAC's fee schedule and terms, regardless of insurance coverage. We don't always know if you have a deductible, if your deductible has been met, or if you have coinsurance.

- We expect payment in full of deductible and coinsurance balances within 30 days of statement receipt unless prior payment arrangements have been made. If services are performed or appointments made that are not covered by your insurance plan, you may be responsible for payment. We may ask that non-emergency appointments be rescheduled if copayment is not paid.

- I authorize my insurance company to make payments directly to FAAC. I authorize the release of any medical information necessary to process claims and/or pursue payments of this account.

Self-Pay or Insurance FAAC does not participate with

- You will need to sign a self-pay waiver if you have no insurance. This waiver clarifies your financial responsibly and helps prevent misunderstandings.

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Referrals

- It is your responsibility to list a physician if your insurance company requires a PCP and call for a referral if one is required. Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist.

- Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance may be your responsibility.

Imaging and Laboratory Fees

- Imaging and Laboratory services are performed and billed by an outside provider. You will be billed from their office and all payments, questions or other concerns should be directed to their office. Flatiron Allergy and Asthma cannot accept payments or adjust these outside provider charges.

Cancellations

- There is a $25.00 charge for no shows or cancellations within 24 hours of your scheduled appointment.

Minor Patients

- The parent/guardian accepts financial responsibility for all services provided by FAAC to a minor patient, regardless of who is the subscriber on the insurance policy.

- Payment of services is due by the adult accompanying any minor child unless other arrangements have been made in advance.

- FAAC will not bill two people for care of a minor patient. It is the responsibility of the accompanying adult to pay the amount due in full and collect what is owed by others.

- FAAC is not party to any legal agreements between divorced or separated parents and therefore is not bound by the terms of any such agreements.

Returned Checks

- There will be a $25.00 charge in addition to any charged bank fees for returned checks. This fee will be applied to my debit/credit card on file. All future payments must be paid with a debit/credit card.

Payment

- I understand that FAAC requires that a credit card (we accept Visa, Mastercard, and Discover), debit card or health savings account card be kept on file and will be billed for any balance owed by the patient.

- If the credit card or health savings account card I provide on file is declined, I understand that I will be charged an extra $25 re-processing fee.

- Accounts past due are subject to collection proceedings and ultimately dismissal for full collection accounts.

- I agree that if my account becomes delinquent, I will be responsible for Attorney Fees, Legal Costs or any other costs of collection that may be incurred in order for FAAC to obtain payment.

I take responsibility for researching the costs of my visit and any procedures related to the visit with my insurance company and understand that costs not covered by certain insurance will be charged to me. I understand that I can discuss any visit related charges ahead of the visit with Flatiron Allergy and Asthma Center's billing department at 970-430-4896.

I have read and accept the terms of this financial policy.

____

Printed Name of Financial Responsible Party

____ ______________

Signature of Financially Responsible Party Date

GENERAL POLICIES

Thank you for choosing Flatiron Allergy & Asthma Center (FAAC) as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your understanding of our policies is important to our professional relationship.

1. I understand that medications are unable to be refilled if I have not followed up within the requested interval.
2. I understand that I may be charged for telephone calls to the provider.
3. I may be asked to reschedule if I am more than 10 minutes late for my appointment.
4. I understand I will be charged a fee of $10 for the completion of each page on a school form. School forms will be not charged if it is brought in during a scheduled office visit.
5. I understand I will be charged fees in accordance to Colorado law for copies of my medical records.
6. I understand I will be charged a fee of $25 for each letter prepared by FAAC.

____ ______________________

Signature of Patient (or Parent/Guardian for Minor Patient) Date

____

Printed Name of Patient

CREDIT CARD ON FILE AUTHORIZATION FORM

Keeping a credit card on file has its benefits:

It's convenient (saving you time and postage).
Your payment is always on time (even if you're out of town).
You can get your credit company's reward points for paying your bill.
You SAVE money by avoiding late fees.

Here's How it Works:

You authorize Flatiron Allergy & Asthma Center to keep your credit card number on file and use it to bill any outstanding balances after third parties pay their portion.

Once all third parties, including your medical insurance, have paid their portion you will receive a statement and have 30 days to review it before your card is charged.

You will receive a reminder call a week before we charge your card. A message will be left if we reach your voicemail.

I ____ authorize Flatiron Allergy & Asthma Center to charge my credit card indicated below for my outstanding balance on an as needed basis.

____	____
Billing Address	Phone Number
____	____
City, State & Zip Code	Email Address

____

Patient Names (list all)

I authorize Flatiron Allergy & Asthma Center (FAAC) to charge the credit card indicated in this authorization form according to the terms outlined above. I understand I may revoke this authorization by providing a written request at least 15 days prior to my card being processed. I understand that FAAC policy is to have a credit card on file for payment and if authorization is revoked without providing another credit card, FAAC may not be able to provide future services. I understand that this authorization will remain in effect until the designated card's expiration date or until I cancel it in writing, whichever comes first, and I agree to notify FAAC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I understand that should my credit card be declined, I may be subject to a $25.00 re-processing fee. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form. I agree to promptly submit written notification to Flatiron Allergy & Asthma Center if my credit card is cancelled, lost or stolen.

Signature:____

Date:_________________________

Updated 4.05.2020