****Please provide insurance card and Driver's License for copies.****

V.M. BOMMANNA, M.D.
Board Certified Allergist

Adult & Children Allergy Asthma Center

Date:

Location: (Circle One)

Clearlake/Webster Pearland Lake Jackson Nacogdoches

Patient Registration Form

(Please print and fill back and front of form as completely as possible)

Last name:_____ First name: _____
Middle Name: _____ Gender: M / F
DOB: ____/____/_____ SSN# _____-_____-_____
Address:_____
City: _____ State: _____ Zip: _____
Home #: (_____)_____-_____Work #: (_____)_____-_____
Cell #: (_____)_____-_____
Marital Status: □ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for ___ years
E-Mail Address: _____
May we contact you by e-mail? □ Yes □ No
Occupation:_____ Employer_____
PCP: _____ Referring Physician:_____
Emergency Contact: _____
Relationship: _____ Contact #(_____)_____-_____
Address: _____
City: _____ State: _____ Zip:_____
****If minor please provide:
Mother's Name _____ Cell # (_____)_____-_____
Father's Name _____ Cell # (_____)_____-_____

Who may we thank for referring you to Allergy & Asthma Center?

Physician_____
Patient_____
Family Friend_____
Phone Book (which one?)_____
Other: _____

Primary Insurance Information

Person responsible for account/ Policy holder: _____
Relation to Patient:_____ SSN# _____
DOB: _____ Gender:_____
Address (If different from patient's):_____
City: _____State:_____ Zip: _____
Employer &Occupation_____
Work Phone #:_____Home Phone # _____
Insurance Name: _____Effective Date: _____
Contract/ID #: _____Group# _____Authorization_____
Deductible: _____ Copay: _____
Names of other dependents covered under this plan:_____
_____

Secondary Insurance Information

Person responsible for account/ Policy holder: _____
Relation to Patient:_____ SSN# _____
DOB: _____ Gender:_____
Address (If different from patient's):_____
City: _____State:_____ Zip: _____
Employer &Occupation_____
Work Phone #:_____Home Phone # _____
Insurance Name: _____Effective Date: _____
Contract/ID #: _____Group# _____Authorization_____
Deductible: _____ Copay: _____
Names of other dependents covered under this plan:_____

Financially Responsible Party/ Guarantor

Last name:_____ First name: _____
Middle Name:_____ Gender:___ DOB: _____ SSN# _____
Address:_____
City: _____ State: _____ Zip: _____
Home #:_____ Work #:_____ Cell #: _____

Minor children must be accompanied by responsible party unless other arrangements have been made in advance. The party accompanying the minor is responsible of payment at the time the services are rendered.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to
Name of Insurance Company(ies)
Dr. Bommanna all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Represenative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Represenative Relationship to Patient

Insurance Assignment Policy Statement

You have selected **"Insurance Assignment"** as the method of choice to take care of your financial obligation with this office.

This option is offered as a courtesy to our patient and as such, you must understand and agree to following:

1. That verification of benefits is not a guarantee of payment. All claims are reviewed by your insurance carrier and reimbursement eligibility is determined at that time. Claims denied for pre-existing conditions or services not covered by your plan are the sole responsibility of the patient.
2. The patient has the responsibility for providing complete information and documents for filing insurance. Without complete and accurate insurance information we are unable to file any claims on the patient's behalf. Our office files only primary insurance. Filing of secondary insurance is the responsibility of the patient.

3. Payment is expected at the time of services unless other arrangements are made in advance. All deductibles and co-insurance will be paid at the time of visit.
4. That if your carrier has not paid a claim within **60 days** of submission, you are responsible to take active part in the recovery of your claim and that after **90 days** you will be responsible for payment in full of any outstanding balance.
5. That in the event you discontinue your program of care prior to doctor's consent, you are responsible for **payment in full of any outstanding balance and the courtesy of insurance assignment is immediately discontinued.**
6. That any insurance check sent to the patient in payment for services that have been filed by our office must be forwarded directly to the physician.
7. A fee will be charged for NSF checks returned to our office.
8. Managed care patients who require referrals from Primary Care Physicians are responsible for staying current regarding status of their referrals.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

PATIENT PHARMACY INFORMATION

Our office will be using an e-Prescription system to handle your prescriptions. Your prescriptions will be transmitted electronically to your pharmacy instead of our office issuing a paper prescription. Please provide us with information about your pharmacy. **YOU MUST PROVIDE THE PHARMACY NAME AND ZIP CODE**.

Patient Name _____

Patient DOB _____

Patient Drug Allergies _____

_____

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone Number _____

Pharmacy Fax Number _____