SIGNATURE
ALLERGY & IMMUNOLOGY

In preparation for your appointment, please read:

1. Please bring all your medications to your appointment.
2. We request that you do not bring multiple family members to your appointment.
3. Minors must be accompanied by an adult.
4. Please be on time for your appointment. For new patients: if you are unable to complete your paperwork before your appointment, kindly arrive 15 minutes early.
5. There is a "no-show fee" for cancellations made within 24 hours of your appointment time.
6. Patients will be asked to reschedule their appointments if they arrive more than 15 minutes past the scheduled time.

The office will make an **initial appointment for a consultation,** and depending on the evaluation after consultation, **a follow-up appointment will be made for allergy testing.**

Testing is offered in the office for:

- Environmental allergies
- Food allergies
- Drug challenges and drug allergies
- Insect stings
- Contact dermatitis
- Asthma
- Primary immune deficiency

Procedures performed in the office include:

- Skin testing, both percutaneous and intradermal
- Allergy injections that include conventional allergy injections, rush, and cluster immunotherapy
- Oral immunotherapy for food
- Desensitization and oral drug challenges
- Patch testing for contact dermatitis
- Pulmonary function test
- Rhinoscopy

*Appropriate tests will be discussed after the initial consultation.

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PATIENT INFORMATION

*****PLEASE PRINT*****

Last Name:	First Name:	MI:	☐ Male ☐ Female

Date of Birth:	Date of Visit:	
Address:		
City, State, ZIP:		
Primary Phone:	Secondary Phone:	
Email:	Parent Name if Minor:	
Race:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	
Preferred Language:	Marital Status:	
Patient's Occupation:	Employer:	
Emergency Contact Name:	Emergency Contact Phone:	Relationship:
Primary Care Physician:	Referring Physician:	
Pharmacy:		
Pharmacy Phone:	Pharmacy Address/Location:	

IF PATIENT IS NOT THE SUBSCRIBER COMPLETE NEXT SECTION:
<u>POLICY HOLDER INFORMATION</u> (ALL INFORMATION REQUIED)
IF WE DO NOT HAVE REQUESTED INFO HERE, YOU MAY RECEIVE A BILL FOR SERVICES.

Policy Holder Name:	Relationship to Patient:
Phone:	Date of Birth:
SSN #:	
Employer:	Employer Address:

(We do not file Automobile, Homeowners or Personal Injury Insurance)
Our office charges a no-show fee of $25 for missed office visits. This is charged when the patient does not notify our office of the intent to cancel an appointment when advanced notice could have been given. If you are unable to keep your appointment, please call us at least 24 hours prior to your appointment at 314-872-3104.

Signature:	Date:

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HEALTH INFORMATION

DO NOT LEAVE ANY QUESTION UNANSWERED

Patient Name:	
Date of Birth:	Date of Visit:
How did you hear about us?	
Email address:	
Do you have any drug allergies?	
List Prescription Medications:	List: Non-Prescription Medications
List your medical history	Surgical history
Do you smoke now, or did you smoke in the past?	
What pets do you have at home?	
Vaccination History – Please list the month and date you received the following: COVID	
Influenza vaccination:	Pneumonia vaccination:
TDap:	Shingles:
Family medical history:	

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SIGNATURE MEDICAL GROUP PAYMENT POLICIES

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to pay by automated payment card by signing a separate authorization.

If the patient is covered by insurance, the following apply:

1. The patient/responsible party or guarantor signing below ("you") must provide us with the patient's current and correct medical coverage/insurance/health plan ("health plan") or other responsible third- party payor.
2. You must follow the rules of the health plan such as providing a valid referral form and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).
3. You are responsible for paying any deductibles and co-payments in the amount specified by the health plan as well as non-covered services or other costs not covered by the health plan.
4. Co-payments, non-covered services and other point of service payments must be paid at the time of service including amounts due for a child regardless of who has the legal obligation, or payment obligation under parental custody, divorce or separation terms.
5. WORK RELATED INJURIES:
   a. If the patient's employer has approved treatment, you will not be charged or billed.
   b. If the patient's employer does not approve treatment and YOU SELECT US FOR YOUR TREATMENT, you may be billed and you may be responsible for payment of services not approved by the employer.
6. If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.
7. We file group health plan claims and by law, must file Medicare claims.
8. If you think your bill contains an error or if you need more information about an item on your bill, contact us at the address or telephone number on your statement.

We expect payment in full at time of service for all charges which are not covered by the patient's health plan.It is your responsibility to contact us in the event of a need for an alternative payment plan or to apply for a discount if you do not have insurance.

In the event of non-payment, you will be responsible for any legal and collections fees. Legal and collection fees will be added to the outstanding balance on the account should the account be referred to an outside agency for collection.

I have read and agree to the above terms and hereby assume full responsibility for paying any medical service charges and collection fees according to these terms.

Print Patient Name: _____ Date of Birth: _____

Print Guarantor Name and Relationship to Patient: _____

Signed: _____ Date: _____

(Patient or Guarantor/Responsible Party, if other than Patient)

Witness to Signature, if applicable: _____ Date: _____

SIGNATURE
ALLERGY & IMMUNOLOGY

PATIENT REGISTRATION CONSENT & ACKNOWLEDGMENTS

CONSENT TO TREAT

I consent to Signature Medical Group (SMG) physicians, practitioners, and other providers ("Provider''), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for the patient named below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending Provider of any decision to terminate treatment. I agree to provide at least 24 hours' notice prior to cancelling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out- of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, Medicaid, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all of the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

Patient Name:	Relationship:	Phone Number:
Patient Name:	Relationship:	Phone Number:
Patient Name:	Relationship:	Phone Number:

Initial all applicable information:

_____ Medical/Treatment/PHI including retrieval of medical records and prescription refills
_____ Lab/Ancillary Testing/Radiology/MRI/Imaging Results
_____ Billing/Insurance Information
_____ Authorized to leave message on voice mail or by other designated communication systems
_____ Other, Describe _____

ADVANCE DIRECTIVES FOR HEALTH CARE *(Living Will/Healthcare Directive, Durable Power of Attorneyfor Healthcare)*
(If applicable to the practice setting, patient to initial appropriate statement):

_____The patient does NOT have an Advance Directive
_____The patient has the following Advance Directive(s): _____
and will provide a copy to the attending SMG physician practice.

Print Patient Name: _____ Date of Birth: _____

Print Guarantor Name and Relationship to Patient: _____

Signed: _____ Date: _____

(Patient or Guarantor/Responsible Party, if other than Patient)

Witness to Signature, if applicable: _____ Date: _____