ALLERGY & ASTHMA CARE OF FAIRFIELD COUNTY, LLC

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55 WALLS DRIVE
FAIRFIELD, CT 06824

500 MONROE TURNPIKE
MONROE, CT 06468

Patient Name: _____
First MI Last Suffix

Patient Home Address: _____
Street

_____ **Email Address**: _____
Zip City State

Race: _____ Language:_____ Ethnicity: Latino:_____ Not Latino _____
(We are required to ask due to new Healthcare Regulations)

Home Phone: _____Other Number: _____
Cell/ Work (please circle)

Emergency Contact Number: _____

Sex: M F **Date of Birth:** _____ Social Security Number: _____
Month Day Year

Primary Care Physician: _____ Physician Phone Number: _____

Referred By: _____

INSURANCE CARDHOLDER INFORMATION

Cardholder: _____
First MI Last

Address only if different from patient: _____
Street City State Zip

Home Phone: _____ Work: _____

Date of Birth: _____ **SS Number:** _____

Subscriber is the: Mother Father Son Daughter Wife Husband Self Other—of the patient (please circle)

Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. If you do not obtain a valid referral, and your insurance company requires one, then services are considered not-covered and you are responsible for payment. It is your responsibility to pay any co-payment and deductible amounts required by your insurance carrier. In order to control the cost of billing, we request that charges for office visits be paid at the conclusion of each visit. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans to the practice named on this form. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of the account or future outstanding accounts. By signing below I acknowledge that I have read and understand the Financial Policy from the new patient information packet.

I authorize your office to leave reminder messages on my voice mail/answering machine.

_____ _____
Signed (patient over 18/parent or guardian) Date

_____
Name (please print)