Freedom Allergy
Allergy Sinus and Cough Center of Georgia

PATIENT REGISTRATION FORM

Acct # _____

Member Information

First Name _____ M.I. ____ Last Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Work # _____

Birth Date ____/____/____ Social Security # _____ or Drivers License # _____

Gender: M / F **Marital Status:** Married Single Divorced Other **Preferred Language:** English Other _____

Ethnicity: Hispanic/Latino Non Hispanic/Latino **Race:** Caucasian African American Asian Other _____

Referred by _____ Primary Physician _____

Responsible Party

First Name _____ M.I. _____ Last Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Birth Date ____/____/____ **Gender:** M / F

Social Security # _____ or Drivers License # _____

Employer _____ Work # _____

Insurance Information

Primary Insurance Company _____

Address _____
Street City State Zip

ID Number _____ Group Number _____

Insured Name _____ Insured DOB _____

Insured Employer _____ Relationship to Patient _____

Secondary Insurance Company _____

Address _____
Street City State Zip

ID Number _____ Group Number _____

Insured Name _____ Insured DOB _____

Insured Employer _____ Relationship to Patient _____

Financial Policy: I authorize the release of any information necessary to process claims. I request payment of benefits to Allergy Sinus and Cough Center of Georgia (ASCCG). I understand I am financially responsible for charges not covered by insurance.

If your plan has a co-payment, deductible and/or co-insurance you will be expected to pay your portion prior to receiving any service including an office visit and/or immunotherapy. If you are on a high deductible plan, you will be required to pay a minimum of 50% at the time of service until we verify your deductible has been met.

Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. Should it become necessary for ASCCG to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/or attorney fees.

I understand and agree if care at ASCCG requires a primary care physician referral; it is my responsibility to see that the referral is current prior to receiving care at DASCCG. If no referral is present in advance I agree to pay for charges at the time of services.

I have read the above Allergy Sinus and Cough Center of Georgia, Inc. financial policy and understand my financial responsibility.

Patient/Responsible Party Signature _____ **Date** _____