Allergy & Asthma Center of Wyomissing

Pediatric & Adult

Henry Scovern, MD

PATIENT INFORMATION (PLEASE PRINT)

NAME: (FIRST/MIDDLE/LAST) **DATE:_____/_____/_____**

_____**SSN#**_____-_____-_____

DATE OF BIRTH:_____/_____/_____ **MALE / FEMALE SING/MARRIED/W/D**

HOME ADDRESS:_____**CITY:**_____

HOME PHONE:_____ **STATE:**_____

WORK:_____ **ZIP:**_____

CELL:_____

EMPLOYER:_____**BUS.#**_____

SPOUSE'S NAME:_____**SSN#**_____-_____-_____

SPOUSE'S DATE OF BIRTH:_____/_____/_____ **EMPLOYER:**_____

PRIMARY DOCTOR:_____**BUS. #**_____

ADDRESS:_____**CITY:**_____**ZIP:**_____

REFERRED BY:_____**TO: DR. SCOVERN**

LIST CURRENT MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____

_____

PHARMACY NAME:_____**PHONE #**_____

IF PATIENT IS A MINOR, PLEASE COMPLETE INFORMATION BELOW:

MOTHER'S NAME:_____**SSN#**_____-_____-_____

MOTHER'S DATE OF BIRTH:_____/_____/_____ **PHONE #** _____

HOME ADDRESS:_____**CITY:**_____ **ZIP:**_____
(IF DIFFERENT FROM PATIENT)

MOTHER'S EMPLOYER:_____ **BUS.#**_____

FATHER'S NAME:_____**SSN#**_____-_____-_____

FATHER'S DATE OF BIRTH:_____/_____/_____ **PHONE #** _____

HOME ADDRESS:_____**CITY:**_____**ZIP:**_____
(IF DIFFERENT FROM PATIENT)

FATHER'S EMPLOYER:_____**BUS.#**_____

(PLEASE COMPLETE INSURANCE INFORMATION ON PAGE 2)

Primary insurance:	**Subscriber:**
ID #:	**Group #:**
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Secondary insurance:	**Subscriber:**
ID #:	**Group #:**

Please read:

On each visit in our office, please present your insurance cards, any forms (completed and signed), your referral if you have an HMO insurance and your co-payment. You are responsible for informing us promptly of any future insurance changes. Thank you.

Office visit co-payments are payable at the time of service. We accept payment by cash, check, Mastercard and Visa. We will bill other co-pays and deductibles as they are due and monthly thereafter. There will be a $5.00 fee added monthly to your account for each billing after the initial bill.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, contact us promptly. Under such circumstances we would be happy to set up a reasonable payment plan with you.

We reserve the right to apply interest charges of 1.5% per month to accounts in which any portion is unpaid 45 days from the date of service and to charge for returned checks. Should the account require referral for collection, you will be responsible for collection costs in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees.

We understand that emergencies and other situations occasionally lead to missed appointments. However, we reserve the right to charge for broken appointments and for appointments canceled with less than 24 hours advance notice.

Insurance Authorization and Assignment

I hereby authorize Allergy & Asthma Center of Wyomissing to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Allergy & Asthma Center of Wyomissing all payments for medical services rendered to my dependents or myself. I have read the Financial Arrangement Section above and I understand that, in addition, I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____