ASTHMA & ALLERGY CLINIC OF MARIN & SF INC.

SCHUMAN TAM, MD.

PATIENT REGISTRATION

Today's Date _____ Language Speaking_____

PATIENT INFORMATION (Please Print) I.D. Verified [ ]

Patient's Name: _____ Sex: ☐ M ☐ F
Last First MI

Parent/Legal Guardian Name (if patient is a minor): _____ Relationship: _____

Patient Date of Birth: _____ Age: _____ Marital Status: S / M / W / D / S

Address: _____
Street City State Zip

Home Phone #: ( )_____ Cell Phone #: ( ) _____

Email: _____ Work Phone #: ( ) _____

Employer or School: _____ Occupation: _____

Emergency Contact Person Name: _____ Relationship: _____

Address (if different): _____ Phone #: ( )_____

Pharmacy Name: _____ Address: _____

Primary Care Physician: _____ Phone #: ( )_____

Referral Physician (if any):_____ Phone #: ( )_____

How did you learn of our practice? ☐ Online ☐ Friend/Relative ☐ Primary Doctor

INSURANCE INFORMATION

Do you have medical insurance? ☐ No ☐ Yes If Yes, please complete the following:

PRIMARY INSURANCE: _____ Effective Date: _____

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name (If other than self): _____ Policy Holder's Date of Birth: _____

Address (if different from patient): _____

SECONDARY INSURANCE (if any): _____ Policy Holder Name_____ DOB_____

The above information is accurate to the best of my knowledge.

_____ _____ _____
Signature Relationship (Self/Parent/Legal Guardian) Date

PLEASE COMPLETE THE *ASSIGNMENT AND RELEASE* AND *AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION* ON THE FOLLOWING PAGE

ASSIGNMENT AND RELEASE

I, (Print Name:) _____, authorize the release of any medical information necessary to process the insurance claim and I authorize payment of medical benefits to the Asthma & Allergy Clinic of Marin & San Francisco, Inc. ("AACMSF") or its supplier for services as described in the insurance claim form. This form also confirms that: (1) I understand that the services provided are necessary and appropriate, and (2) I have been advised of my financial responsibility with respect to the services received. **PATIENT RESPONSIBILITY**: I acknowledge that AACMSF will submit claims to my insurance, but I am ultimately responsible for all charges for services provided (including, but not limited to, payment for charges that are: not included in my insurance benefits, not authorized by my insurance, not considered a medical necessity by my insurance, or any late payment fee/ interest). I also acknowledge that co-payments are due at the time the services are provided. I will be responsible for obtaining a referral if required by my insurance and I will check with my insurance plan in regards to my benefits and coverage.

IF PATIENT IS A MINOR: I authorize the provision of medical care for the below-named patient by physicians at AACMSF. I hereby assume full financial responsibility for payment of medical services for the below-named patient in accordance with the terms as set forth in the authorizations and acknowledgments above.

OFFICE POLICY: For missed appointments or appointments cancelled with less than a 48-hour notice, there is a $50 fee for new patients and $35 fee for returning patients.

Patient Name: _____ DOB:_____
Last Name First Name

_____ _____ _____
Signature Relationship (Self/Parent/Legal Guardian) Date

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Do we have your permission to: **(Must Complete)**

1. Leave a detailed message regarding your medical information and/or account on your
Home answering machine: ☐ Yes ☐ No Cell: ☐ Yes ☐ No Work: ☐ Yes ☐ No
2. Discuss your medical condition with someone other than your physician (i.e., family members):
☐ Yes ☐ No
OR, discuss your child's medical condition with someone other than his/her physician, parents or legal guardian: ☐ Yes ☐ No
3. If yes to (2):
   Name of individual: _____ Relationship: _____
   Name of individual: _____ Relationship: _____

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF PROVIDER'S NOTICE OF PRIVACY PRACTICES WITH THE EFFECTIVE DATE OF APRIL 14, 2003.

_____ _____
Patient/Parent/Legal Guardian Signature Date

"NOTICE TO CONSUMERS: Medical doctors are licensed & regulated by the Medical Board of CA (800)633-2322, www.mbc.ca.gov."