Adult & Pediatric Allergy, Asthma and Skin Centers of North Alabama

Decatur • Huntsville • Scottsboro

Mahipal Ravipati, M.D.

First Name_____ Middle Name_____ Last Name_____
Address_____ City, State_____ Zip_____
Home Phone_____Cell Phone_____
Email Address_____
Birthdate_____ Age_____Sex_____SS#_____
Family Physician's Name _____Referring Physician_____
Employer_____ Employer Phone #_____
Pharmacy preference_____City_____

Insured/Responsible Party Information

First Name_____ Last Name _____D.O.B._____
Address_____ City, State_____Zip_____
Home Phone_____ Employer_____

Insurance Information

Insurance Co.	Contract #	Group #	Relationship to Insured
Primary			
Secondary			

Other Information

Father's Name_____ Birthdate_____ SS#_____
Employer_____ WorkPhone_____

Mother's Name_____ Birthdate_____ SS#_____
Employer_____Work Phone_____

Parents Marital Status (check one)------Single_____ Married_____ Widowed_____

In Case of Emergency Contact: _____
Day Phone #_____ Night Phone#_____

URGENT APPOINTMENTS

Are USUALLY brought in and seen the same day you call in. **If you need emergency care call 911 or go to the nearest Emergency Facility.** If you frequent our office for your allergy injections **and have questions for a nurse / doctor or if you are ill PLEASE CALL AND MAKE AN APPOINTMENT.** This allows us to book the appropriate amount of time needed with the Doctor this will reduce your wait time. **If you are more then 20 minutes late without notification to your appointment it may have to be rescheduled to another day, if possible we will work you in.**

FINANCIAL ARRANGEMENTS:

Payment must be paid at the time your appointment. This includes all **Co-payments and deductibles**. We accept **Cash**, **Personal Checks, Master Cards, Visa and Discover**. There is a **$30 CHECK RETURN FEE** for each check that is returned. If we get a NSF check only cash or credit card will be accepted. **If other financial arrangements need to be made, you must speak to our Business Office before your schedule appointment. Adult and Pediatric Allergy, Asthma, and Skin Centers of North Alabama does utilize a collection agency for over due accounts, A collection fee will be added to all accounts.**

CANCELLATION FEE:

All appointments that are not kept will be charged $30, for Failure to cancel my appointment 24 hours prior to the scheduled appointment time. This fee will be charged to your account, Payable on or before your next appointment. TO ALL PATIENT**: FAILURE** TO KEEP OR CANCEL UP TO **THREE APPOINTMENTS CAN RESULT IN THE DISCHARGE FROM ALLERGY ASTHMA SPECIALIST,** THE DECISION TO DISCHARGE A PATIENT FROM OUR CARE WILL BE AT OUR DISCRETION**. PLEASE DO NOT LET THIS HAPPEN TO YOU. New patient appointments are subject to a $50 charge for appointments not canceled 24hrs in advance.**

HMO /PPO /POS/MEDICARE HMO/TRICARE HMO PATIENTS*:*

ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to Adult & Pediatric Allergy, Asthma, and skin Centers of North Alabama medical benefits or Medicare benefits otherwise payable to me under the terms of my policy for the claims filed by Dr. Ravipati, but not to exceed my indebtedness to Dr. Ravipati. In making this assignment to Dr. Ravipati, I understand and agree that any unpaid balances not covered by this policy/Medicare plan, **will be payable by me**. I authorize Medicare to make payment for services rendered directly to Adult & Pediatric Allergy, Asthma, and skin Centers of North Alabama**. I understand I must provide current insurance information at each visit and a Photo ID**. I agree to be financially responsible for payment of all services on my behalf or my dependents.

I hereby certify the information provided is correct and true to the best of my knowledge.

X_____ Date: _____

Signature of Patient/Guardian Print Name

AUTHORIZATION AND RELEASE:

I **Authorize**. Adult & Pediatric Allergy, Asthma, and skin Centers of North Alabama to **release or obtain** any/all information needed to file a medical claim and or treat, diagnose, including my medical records and diagnosis of any treatment or examination rendered to me or my dependent during the period of such care, including, Office notes, Allergy test, Pulmonary Test, Labs, Radiology, my insurance company information, including third party payers and/or other health practitioner or medical facility including Medicare/Social Security Administration & Health Care Financing Administration or its intermediaries.

I **Authorize** my insurance company/Medicare/Social Security Administration & Health Care Financing Administration or its intermediaries to review any/ or all parts of my medical records, for the sole purpose of quality assessment and payment.

I **Authorize** Adult & Pediatric Allergy, Asthma, and skin Centers of North Alabama and the health care staff to perform the necessary medical services I or my dependent may need. **This consent is good for the entire time period I or my child(ren) am/are a patient .**

X_____ Date: _____

Signature of Patient/Guardian Print Name