

**Welcome to Portland Allergy & Asthma!**

We are excited to meet you and wanted to give you some helpful tips to prepare for your first appointment with us.

1. Please bring insurance cards, photo ID and all new patient paperwork filled out in its entirety. Disregard if completed online.
2. Bring all medication or a complete list of your current medications, including over the counter medications and supplements.
3. Please allow up to 1.5 hours for your first appointment.
4. Please call 48 hours in advance if you need to cancel or reschedule to avoid a $40.00 no show fee and potential cancellation of your referral.
5. Due to social distancing guidelines, no additional visitors will be allowed. Parents of a child being treated are the exception.
6. Masking guidelines are still in effect. Please come prepared.
7. If you have any symptoms of Covid or another respiratory illness, please call the clinic and speak to a member of the nursing staff prior to coming in for your appointment.
8. Cash pay and co-pay are expected at the time of service to prevent additional billing charges.
9. Young adults under the age of 18 are required to bring a parent or legal guardian.

Your appointment is scheduled for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At the marked location:

***Please make note to avoid going to the wrong location***

\_\_\_\_Southeast: 8740 SE Sunnybrook Blvd # 300, Clackamas 97015 PH 971-358-5600

\_\_\_\_Southwest: 9370 SW Greenburg Rd # 311, Portland 97223 PH 502-245-8060

\_\_\_\_Northeast: 2150 NE Division Street # 202, Gresham, 97030 PH: 971-358-5800

Fax Number for all locations: 971-358-5801

**Patient Registration Form**

**( Please complete in its entirety to ensure proper billing and insurance payment)** Date:\_\_\_\_\_\_\_\_\_\_\_

\*Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Name:\_\_\_\_\_\_\_\_

\*Legal Sex: M or F DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Pronouns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Driver’s License ( responsible party) #:\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**( signature on this form gives us permission to text or email based on clinic needs)**

Would you like to sign up for the patient portal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party if under 18:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone#\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grp:#\_\_\_\_\_\_\_\_\_

**(Please provide even if you are giving us your insurance card)**

Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grp#\_\_\_\_\_\_\_\_

Policy Holder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location/Ph #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider/PCP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**( Continued on next page)**

**Releasing information to other parties including insurance companies and adults over 18 that are still on parent’s insurance:**

I authorize Portland Allergy & Asthma to share and/or release my medical/billing information to the following individuals: I understand that I can cancel this consent at any time (in writing to Portland Allergy & Asthma) but that canceling it will not affect any information that has already been released. PLEASE PRINT ALL NAMES LISTED BELOW. PLEASE DO NOT LIST PHYSICIANS

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_

I authorize the discussion of billing/financial information only, not medical information to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or, I decline permission to discuss my medical/financial information with others outside of insurance companies or medical providers.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( initial)

**Clinic and Financial Policies:**

1.I understand it is my responsibility to pay my copay at every visit, or I may incur a $10.00 billing charge.

2. I understand that there is a $40.00 no-show fee incurred for any appointments not canceled within 24 hours, and that failure to pay no show fee and a chronic no-show history may result in discharge from the practice.

3. I understand that although Portland Allergy and Asthma will provide me with good faith estimates *when requested* prior to any services being done, it is ultimately my responsibility to coordinate benefits with my insurance company for Allergy/Asthma services covered under my plan, and primary care physician if a referral is needed prior to being seen.

4. I understand it is my responsibility to make sure that Portland Allergy and Asthma is in network with my insurance. I understand that any charges not paid by my insurance company are my responsibility and agree to pay in a timely manner or work with the billing department on payment arrangements.

5. I understand that if my account falls into a delinquent status, I will be unable to make further appointments, fill/refill prescriptions or get allergy/venom shots until my account is brought current.

6. I understand that although Portland Allergy and Asthma will do the best to work with me on my financial matters, if my account is delinquent for over 120 days, it will result in being discharged from the practice and my account being turned over to a collection agency

7. I understand that Portland Allergy and Asthma charges a $30.00 NSF fee for any payments returned from the bank, and that I will then need to pay Cash or Credit/Debit Card moving forward.

We accept Cash, Check, Debit Card,FSA and HSA Card, Visa, MasterCard, Discover and American Express.

***High Deductible Plans***

PDX- Allergy & Asthma recognizes the challenging times we are all facing. We are available to speak with you and can assist you with making arrangements to pay your bill. Please reach out to us if you have any questions or concerns. A deductible deposit will be requested for services if your remaining deductible is over $1000.00. **You** **will be required to pay a 20% Deposit before the services can be done. We will collect 20% of the total services cost or 20% of remaining deductible balance; whichever is lower for the Deductible Deposit amount.** Co-payments and Coinsurances will be requested at the time of service. If payment arrangements are needed, we ask that they be set up within 15 days from receiving your bill and prior to statement due date; whenever the bill cannot be paid in full at the time of the first billing statement. When Payment Plans are set up, they are set up for the patient balance at that time. Any future visits will not be included in the monthly payment plan. You will be responsible for paying for all future visits in full, in addition to your monthly payment plan. If, at any time, any of your future visits are over $300.00, please contact the Billing Department to see if we can combine it with your existing payment plan. Anytime there are new balances added to your existing payment plan, we will have to increase the monthly payment plan amount. The account guarantor is responsible for making appropriate financial arrangements with the Billing Department.

If payment arrangements are needed, the payment schedule is as follows:

Balance/ Months to Pay:

Under $74.99 1 month

$75.00 to $149.00 2 month

$150.00 to $499.99 3 month

$500.00 to $999.99 4 month

$1,000.00 to $1,499.99 8 month

$1,500 to $3,999.99 12 month

$4000.00 or more 20 month

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to these terms and conditions.\_\_\_\_\_\_\_

 ( patient signature) (date)

**Agreement/Authorization**

My signature below indicates that I accept and understand the above policies and give Portland Allergy and Asthma permission to speak with and bill my insurance company on my behalf, including the release of needed medical information. I also hereby authorize payment of medical benefits to Portland Allergy and Asthma when an assigned claim is filed.

Patient/Responsible Party Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand [I can](https://www.lawinsider.com/clause/right-to-revoke) revoke this authorization at any time by written notice of my decision to:
* Portland Allergy and Asthma, ATTN: Kimberley B. 2150 NE Division Street Ste 202, Gresham, OR 97030.
* If I withdraw this authorization, Portland Allergy and Asthma may not afterwards disclose my information for the purpose listed above. However, I cannot retroactively revoke authorization if disclosure has already occurred.Should I revoke this authorization in regards to my insurance company, I understand that I will be responsible for 100% of my bill due to the practice not being able to bill the insurance company without authorization.