Portland Allergy & Asthma

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:

_____ SouthEast_____ NorthEast
9200 SE 91st Ave, Ste 2202150 NE Division St, Ste 202 Happy Valley, OR 97086Gresham, OR 97030
P: 971-358-5600P: 971-358-5800

Patient Registration Form (Please complete in its entirety)

Date:_____

*Legal Name:_____Preferred Name:_____
*Legal Sex: M or F DOB_____Preferred Pronouns:_____Gender_____
Address;_____
Occupation:_____Driver's License #:_____
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?_ Yes

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:_____

Releasing information to other parties including 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 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 beingdone, 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.

~~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 understandI canrevoke this authorization at anytime 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.