ROBERT M. ZEMBLE, M.D.  CAITLIN HOUCK, MSN, CRNP, FNP-C
(610) 820-9000  (610) 820-9078 FAX

# PATIENT INFORMATION

PATIENT NAME____________________________________

ADDRESS____________________________________

____________________________________

PHONE # HOME____________________________________

WORK____________________________________

OK TO CALL YOU AT WORK? YES NO

EMPLOYER NAME/ADDRESS______________

____________________________________

CELL #____________________________________

OK TO CALL YOUR CELL? YES NO

EMERGENCY____________________________________

SOC SEC #____________________________________

BIRTHDAY____________ AGE________GENDER________

MARITAL STATUS____________________________________

SPOUSE'S NAME____________________________________

**DR. INFORMATION IS REQUIRED**
REFERRING DR. NAME/ADDRESS/PHONE NUMBER

____________________________________

____________________________________

**DR. INFORMATION IS REQUIRED**
FAMILY DR. NAME/ADDRESS/PHONE NUMBER

____________________________________

____________________________________

INSURANCE NAME____________________________________

SUBSCRIBER NAME AND BIRTHDAY________________

____________________________________

SUBSCRIBER EMPLOYER NAME/ADDRESS__________

____________________________________

POLICY #____________________________________

GROUP #____________________________________

2ND INSURANCE NAME____________________________________

SUBSCRIBER NAME AND BIRTHDAY________________

____________________________________

SUBSCRIBER EMPLOYER NAME/ADDRESS__________

____________________________________

POLICY #____________________________________

GROUP #____________________________________

## GUARANTOR INFORMATION (DEPENDENTS ONLY - 18 YRS AND YOUNGER)

MOTHER'S NAME____________________________________

ADDRESS____________________________________

____________________________________

PHONE # HOME____________________________________

WORK____________________________________

SOC SEC #____________________________________

DATE OF BIRTH____________________________________

EMPLOYER NAME/ADDRESS________________________

____________________________________

FATHER'S NAME____________________________________

ADDRESS____________________________________

____________________________________

PHONE # HOME____________________________________

WORK____________________________________

SOC SEC #____________________________________

DATE OF BIRTH____________________________________

EMPLOYER NAME/ADDRESS________________________

____________________________________

****NAMES OF FAMILY WHO ARE PATIENTS HERE:** ____________________________________

**PLEASE SEE REVERSE SIDE FOR OUR INSURANCE AND FINANCIAL POLICIES**

# FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

## INSURANCES:

We currently participate with the following insurances: Aetna, Amerihealth Administrators, Amerihealth Caritas (established patients only), Capital Blue Cross, Highmark/Populytics, Cigna, Geisinger, Health America, Health Assurance, Health Guard, Highmark Blue Shield, Independence Blue Shield, Keystone Health Plan Central, Keystone Health Plan East, Keystone Freedom Blue, Medicare, United Healthcare, and UPMC. This is not a complete list. Please verify our participation with your plan prior to your appointment.

If we do participate with your insurance company, most services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. ***All*** co-pays, co-insurances, and deductibles are the patient's responsibility and will be billed to you by our office.

Most HMO insurances require insurance referrals for all dates of service. ***It is the patient's responsibility to obtain the referral prior to the time of service.*** The patient will be responsible for the cost of the services performed at their appointment if a referral is NOT presented at the time of service,

If we do not participate with your insurance company we will not bill your insurance carrier, and, we will not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay; however, our fees may be more than what the insurance company shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient. Payment of service performed IS due at the time of service. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

Patients should check with their insurance prior to their appointment to be sure our services are a covered expense and to verify what charges the patient may be responsible for; i.e. deductibles, co-pays, co-insurance etc.
Some examples of services which may be done at the first visit: new patient visit 99202 - 99205 (these charges range from $85.00 - $240.00); PFT's 94060 ($90), allergy skin tests 95004, 95024 (can run as high as $600.00 for testing). Please feel free to contact us if you need additional information regarding your potential charges. The services performed vary based on age of patient and necessity.

**It is the patient's responsibility to understand their insurance carrier's coverage's, rules and regulations.** Our office accepts Visa, MasterCard, Discover, American Express, check and cash. All payments are expected at the time of service.

**High Deductible Health Plans:** The patient is responsible for a portion of the deductible at the time of service should the deductible not be met. Our office will notify you of the amount due prior to your new patient or 1st allergy injection appointment. You may owe an additional balance after your claim processes with the insurance. This balance may be several hundred dollars, depending on the amount of skin tests performed, level of office visit etc.
Patient co-pays will be charged should the patient not provide 24 hour notice or "no show" for their appointment.
A $5.00 billing fee will be assessed to all accounts not paid at the time of service–this includes co-pays. NO EXCEPTIONS.
A $25.00 charge will be assessed to accounts whose checks do not clear the bank.

You agree, in order for us to service your account or to collect monies you may owe, Allentown Asthma & Allergy and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending test messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.
I have read this disclosure and agree that Allentown Asthma & Allergy, its employees and/or agents may contact me/us as described above.

## PLEASE READ AND SIGN BOTH AREAS

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ALLENTOWN ASTHMA AND ALLERGY AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_______________________________________ ____________________

Signature of Patient/Guardian Date

I give the office of Allentown Asthma and Allergy my permission to release any of my/my child's information and/or records (either by telephone or by mail) to all of my insurance companies.

_______________________________________ ____________________

Signature of Patient/Guardian Date