Food Allergy Center of Florida

Windom Allergy, Asthma & Sinus

SCR Sarasota Clinical Research

Jean Ly, MD | Hugh H. Windom, MD | Jennifer Fergeson, DO

PATIENT	Today's Date _____
Name (First, Initial, Last):	Date of Birth:
Local Address:	Northern Address:
City: State: Zip:	City: State: Zip:
Marital Status: ☐ Married ☐Divorced ☐Widowed ☐ Separated ☐ Single	
Phone (H) (M) (W)	Occupation:
SPOUSE OR PARENT (if Patient a Minor)	
Name (First, Initial, Last):	
Phone (H) (M) (W)	Occupation:

How Did You Hear About Us? ☐ Friend _____ ☐ Doctor _____ ☐ Other _____

Who is Your Regular Physician? _____ Address/phone if out of town _____

Any family member a current patient in this office No Yes (Please List) _____

Preferred Pharmacy: _____Street Address_____ City_____

INSURANCE INFORMATION

Submit your insurance card with completed form so we can make a copy for your chart.

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
Insurance Company:	Insurance Company:
Policyholder:	Policyholder:
Policyholder Relationship: ☐ Self ☐ Spouse ☐ Parent	Policyholder Relationship: ☐ Self ☐ Spouse ☐ Parent
Policyholder Birthdate:	Policyholder Birthdate:
Employer/Phone:	Employer/Phone:

Benefit Assignment and Release of Information:

I hereby authorize the assignment of benefits (payments) directly to **Windom Allergy** for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. **I will be paying today by: ☐ Cash ☐ Check ☐ MC / Visa**

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient Signature of Responsible Party (if different)

Billing Policy

We will submit charges, at our expense, to your insurance company on your behalf. If it turns out that you owe a portion of the bill or your carrier fails to pay us after 2 attempts to contact them, we will send you a bill. If there is no response from you in 30 days, a $25 late charge will be assessed.