Complete and then fax this form to (480) 834 – 6244 and bring it with you to your appointment.

Family Allergy Clinic

Dr. Stuart Agren

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Social Security: _____ Date of Birth: _____ Sex: _____

Employer Name: _____ Employment Status: _____

Employer Address: _____ City: _____State: ____ Zip: _____

In case of emergency notify: _____ Phone: _____

Responsible Party Information:

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Social Security: _____ Date of Birth: _____ Sex: _____

Employer Name: _____ Employment Status: _____

Employer Address: _____ City: _____State: ____ Zip: _____

In case of emergency notify: _____ Phone: _____

Relationship to Patient: _____

If the patient is a minor: I hereby certify that I am legal guardian of the above minor and authorize the healthcare provider to perform the necessary procedures required for medical evaluation and treatment.

The patient/responsible party acknowledges that the above information is true and correct, accepts responsibility for all services rendered, and that he/she is contractually bound to pay for services rendered.

Signature: _____ Date: _____

3048 East Baseline Road Suite 122 Mesa, AZ 85204 (480) 827-9945

Family Allergy Clinic

Dr. Stuart Agren

Insurance Billing Policies

If you do not have insurance or your service is not covered by insurance, payment is required at the time the service is rendered.

We will be happy to bill your primary medical insurance for our services. In order to do this, we require complete and accurate insurance information. All patients are responsible for their own balances. If your insurance does not pay after 60 days, we will either bill you or ask you for your intervention with your insurance carrier to get the claim paid. If any proceedings or actions shall be brought against me to recover any outstanding balance, the undersigned agrees to pay all costs and expenses acquired including reasonable attorney's fees. Please complete your insurance information below:

Policyholder name: _____ Policyholder sex: _____

Policyholder address: _____

City: _____ State: _____ Zip: _____

Policyholder ID #: _____ Group: _____

Policyholder date of birth: _____ Policyholder social security #: _____

Insurance company name: _____ Phone: _____

Claim address: _____

Your payment portion / co-pay are due at the time of each visit. Payment is due immediately upon receipt of a statement from us or upon receipt of explanation of benefits from your insurance carrier. We do not bill any third party insurances. Therefore, you are responsible for payment for those types of services.

Insurance billing prices for our services:

New patient office visit: $153.54
Established patient office visit: $61.80 – $152.75
Allergy testing ranges from $95.60 to $534.60 depending on units tested
Antigen serum: $22.95 per unit *(start-up packs are 93 units, maintenance serum is 30 units*)

I have read and understand the above information. I accept financial responsibility for my services as outlined above. I request that payment of authorized insurance benefits be made either to me or on my behalf to Dr. Agren's Family Allergy Clinic. I authorize medical or other information needed for my claims to be released to the insurance carrier(s) or Health Care Financing Administration. I permit a copy of the authorization to be used in place of the original.

Signature: _____ Date: _____

3048 East Baseline Road Suite 122 Mesa, AZ 85204 (480) 827-9945

Family Allergy Clinic

Dr. Stuart Agren

Notice of Privacy Practices

I have reviewed and am aware of the **Notice of Privacy Practices**, which is also posted with the office for my review. I further understand that I can request that my Protected Health Information be limited by requesting so in writing to the Privacy Officer. I understand that this authorization meets the needs of **HIPPA (Health Insurance Probability and Accountability Act)** guidelines set forth by the Federal Government in regards to patient confidentiality.

Signature: _____ Date: _____

Consent for Treatment

I _____ give permission to Stuart H. Agren, MD to care and treat me *(and/or my minor children).*

For minor child: I understand that my child cannot be treated without my presence unless I've given written consent to an adult over 18 to seek such care or treatment. In my absence the following adults over the age of 18 may seek medical attention for my minor child:

Name _____ Relationship _____

Name _____ Relationship _____

Signature: _____ Date: _____

3048 East Baseline Road Suite 122 Mesa, AZ 85204 (480) 827-9945

Family Allergy Clinic

Dr. Stuart Agren

Name _____ Date _____

Occupation _____ Age _____

COMPLAINTS: Please circle the appropriate number according to severity: 1 = mild, 5 = very severe, 0 = no problem

Nasal discharge	0 1 2 3 4 5	Chronic fatigue	0 1 2 3 4 5
Nasal obstruction	0 1 2 3 4 5	Food intolerance	0 1 2 3 4 5
Watery or itchy eyes	0 1 2 3 4 5	Frequent sinus or ear infections	0 1 2 3 4 5
Sneezing	0 1 2 3 4 5	Frequent colds or sore throats	0 1 2 3 4 5
Wheezing	0 1 2 3 4 5	Learning disability	0 1 2 3 4 5
Cough	0 1 2 3 4 5	Poor memory or concentration	0 1 2 3 4 5
Itching	0 1 2 3 4 5	Hyperactivity	0 1 2 3 4 5
Eczema	0 1 2 3 4 5	Abdominal gas or cramping	0 1 2 3 4 5
Hives	0 1 2 3 4 5	Arthritis or muscle aching	0 1 2 3 4 5
Headache	0 1 2 3 4 5	Asthma	0 1 2 3 4 5

Other symptoms _____

_____

Which (if any) foods cause you problems? _____

In what year did your allergies start? _____ How many months of the year do you have allergies? _____

Have you been allergy tested before? _____ If yes, did you receive desensitization shots? _____

What prescription medications have you tried for allergies? How long did you use them?

1._____ for how long? _____

2._____ for how long? _____

3._____ for how long? _____

Does any medication give you relief of symptoms? _____

List any animals you have in or around the home _____

List any medication allergies you have _____

Do you smoke? _____ How much? _____ Smoky work environment? _____

Who else in your family has allergies? _____

How did you hear about the Family Allergy Clinic? Please be specific. (If newspaper, please give name)

3048 East Baseline Road Suite 122 Mesa, AZ 85204 (480) 827-9945