ALLERGY CENTER OF CONNECTICUT

PATIENT INFORMATION

NAME (Please print): _____ Date of birth: _____

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

Home phone (____)_____ Cell phone (____)_____ Work phone (____)_____

Gender: ❑ Female ❑ Male Preferred Language: _____ Ethnicity (optional): _____

Email: _____

Pharmacy: _____ Phone: (____)_____

In case of emergency who should be notified? _____ Relationship: _____

Home phone (____)_____ Cell phone (____)_____ Work phone (____)_____

❑ Referred by a Doctor _____

❑ Referred by a Patient _____

❑ Insurance company or Website _____

Primary Physician: _____

Phone: (____)_____

Adult responsible for payment (Please print): ❑ Same as above

_____

Relationship to patient: _____ DOB: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Home phone (____)_____ Cell phone (____)_____ Work phone (____)_____

MEDICAL HISTORY

GOAL OF VISIT: _____

CHRONIC MEDICAL CONDITIONS: _____

_____

CURRENT MEDICATIONS: _____

_____

_____

ALLERGIES (TO FOODS OR MEDICATIONS): _____

_____

_____

** Your **insurance** will determine which medications are covered and their cost. If there is a medical necessity, then an **appeal or prior authorization** will be submitted on your behalf. Please allow 48 hours for processing.

4 Corporate Dr, Suite 295, Shelton, CT - phone: 203-374-6103, fax: 203-374-1663
761 Main Ave, Suite 105, Norwalk, CT - phone: 203-870-8731, fax: 203-803-2730
www.allergyct.com

ALLERGY CENTER OF CONNECTICUT

AGREEMENT AND CONSENT FOR MEDICAL SERVICES

1. **Agreement and consent.** I hereby authorize medical services to be provided by the physicians and medical staff of the Allergy Center of Connecticut, P.C. until revoked by me in writing.

2. **Release of information.** I hereby authorize the Allergy Center of Connecticut, P.C. and all physicians involved with my care to release information from my medical records as may be required to any person, corporation or agency which is legally responsible or which the Allergy Center of Connecticut, P.C. has good cause to believe is legally responsible, for processing and/or paying all or any part of the Allergy Center of Connecticut, P.C.'s charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize the Allergy Center of Connecticut, P.C. or any physician involved with my care to release information to any physician or health care facility to which I may be transferred for further medical care.

3. **Assignment of Insurance Benefits.** I authorize that payment be made directly to the Allergy Center of Connecticut, P.C. for any insurance benefits payable for those services provided by the Allergy Center of Connecticut, P.C. This authorization expressly includes any benefits that are to be provided by Medicare and any other public or private insurance plans. This order will remain in effect until revoked by be in writing.

4. **Acknowledgment of Financial Responsibility:** I acknowledge the Allergy Center of Connecticut, P.C. Financial Policies (below). I have read and thoroughly understand the financial policies, and I agree to accept financial responsibility as described. I hereby agree to pay the Allergy Center of Connecticut, P.C. the charges for all medical services rendered. If I am agreeing and signing on behalf of a minor patient, I affirm that I have the legal right to consent and agree on behalf of that minor.

5. **Acknowledgment of Notice of Privacy for Protected Health Information**. I acknowledge the Allergy Center of Connecticut, P.C. Privacy Policies (below). I have read and thoroughly understand the privacy policies, and I agree to the policies as described.

6. **For minors.** I acknowledge that I am the parent or legal guardian with full authority to make medical decisions.

6. **I HAVE READ AND AGREE TO THE FOLLOWING ATTACHED DOCUMENTS:**

Financial policy	E-prescribing consent
Privacy policy	Email Consent

_____

Print Name of Patient (or Parent/Guardian for minor) - Signature - Date

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