Allergy and Asthma Center of Montana, PC

401 15th Ave S. Suite 104 Great Falls, MT 59405
Phone (406) 771-9050 Fax (406) 761-1090

PATIENT REGISTRATION

(Please print clearly)

Full Name_____DOB_____Male/Female
Address_____City/State/Zip_____
Home Phone _____Cell Phone_____Work Phone_____
Social Security #_____Employer_____
Pharmacy of Choice_____Occupation_____

Status: □ Single □ Married □ Divorced □ Widowed
Race: □ American Indian □ Asian □ Native Hawaiian □ Black or African American □ White □ Hispanic □ Other Race
Ethnicity: □ Hispanic □ Non Hispanic
Language: □ English □ Indian □ Spanish □ Russian □ Tagalog □ Thai □ Other_____

Parent and/or Spouse's Name_____DOB_____
Social Security #_____Phone #_____
Employer_____Employer Phone_____

Primary Provider_____Referring Provider_____

PRIMARY INSURANCE INFORMATION

Insurance Company_____Policy Holder_____
CoPay_____Social Security #_____Date of Birth_____
Subscriber #_____Group #_____

SECONDARY INSURANCE INFORMATION

Insurance Company_____Policy Holder_____
CoPay_____Social Security #_____Date of Birth_____
Subscriber #_____Group #_____

INFORMED CONSENT FOR TREATMENT

I understand that I am now under the care and supervision of the providers of Allergy and Asthma Center of Montana, PC. I understand that it is the responsibility of Allergy and Asthma Center of Montana, PC and its staff to carry out the instructions of the providers. I consent to medical/allergy testing services rendered to me and the expressed or implied instruction of my provider. I understand that any services furnished to me outside of the scope of any instruction, express or implied, of my provider or designee are not performed on behalf of , or at the direction of Allergy and Asthma Center of Montana, PC.

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with above listed insurance company and assign directly to Allergy and Asthma Center of Montana, PC all insurance benefits. If any otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges on all insurance submissions. The above named facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or in one year from the signed date below.

_____ _____

Signature of Patient or Patient Representative **Date**

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Prescription Consent

I give my consent to have Asthma and Allergy Center of Montana obtain my prescription history from external sources.

_____ _____

Signature of Patient or Patient Representative **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the Allergy and Asthma Center of Montana's Notice of Privacy practices.

Signature:_____Date:_____

EMAIL AUTHORIZATION AGREEMENT

Allergy and Asthma Center of Montana may choose to discontinue e-mail communication at any time.

Privacy and Security of E-mail

Do not use e-mail to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, and e-mail sent on your employer's system may be viewed by your employer.

Asthma and Allergy Center of Montana cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through e-mail.

This document along with Allergy and Asthma Center of Montana "Notice of Privacy Practices" constitutes a notice of privacy practice for e-mail use.

Authorization to use e-mail

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail as one form of communication with my physician, and his/her associates, technicians and other healthcare providers.

You will be given a copy of this signed form to keep for your records.

Patient Signature_____Date_____

Patient e-mail address_____

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Contact Consent

With consent, Allergy and Asthma Center of Montana, and/or representatives thereof may call my home or other designated location and may leave messages on a voicemail or in person in reference to any items that assist our office in carrying out treatment or payment options which may include but are not limited to – procedures done during visit, diagnosis used for billing purposes, insurance items including denial reasons, and balance of account.

Home/Cell Phone_____Work phone_____

- ☐ OK to leave a detailed message
- ☐ OK to leave detailed message with person
- ☐ OK to fax to this number_____
- ☐ Leave message with call back number only
- ☐ OK to leave message with call back number only
- ☐ OK to leave message with detailed information at work #

Written/Electronic Communications

- ☐ OK to mail to my home address
- ☐ OK to mail to my work office
- ☐ OK to send via my request to the following email_____

I acknowledge that this information will only be sent upon request and is not guaranteed to be sent securely._____
Initials

Persons that are **ABSOLUTELY NOT** to have my PHI	Persons who **ARE ABLE** to discuss my PHI
_____	_____
_____	_____
_____	_____

By signing this form, I am consenting to Allergy and Asthma Center of Montana, and/or representatives to use and disclose my PHI to carry out treatment and payment options. I may revoke my consent in writing except in the extent that the practice has already made disclosures in reliance upon my prior consent. This form will remain in effect until otherwise noted.

_____

Signature of Patient **Date**

_____

Printed Name of Patient