Family Allergy & Asthma Care Consultants, LLC
Shankar Lakhani, MD Board Certified Allergy & Asthma Care
Diplomate, ABAI, ABP
Renee Cumens, PA-C

ACCT # _____

PATIENT INFORMATION (PLEASE PRINT, Black Ink only)

Last Name _____ **MI** _____ **First Name** _____

EMAIL_____**Race**_____**Ethnicity**_____**Language**_____

Social Security # _____ **Date of Birth** _____**Male or Female**

Street Address _____ **P.O. Box** _____

City _____ **State** _____ **Zip Code** _____**Employer**_____

Home Phone _____**Cell Phone** _____ **Work Phone** _____

Primary Care Doctor _____**Referring Doctor** _____

PARENT/LEGAL GUARDIAN INFORMATION

Are you the Parent or Legal Guardian of the patient? _____If not relationship_____ (we will need legal papers if guardian)

MOTHER

Last Name _____ **First** _____ **MI**_____

Social Security # _____**Date of Birth** _____

Street Address (if different from above) _____

City _____ **State** _____**Zip** _____**Employer**_____

FATHER

Last Name _____ **First** _____ **MI**_____

Social Security # _____**Date of Birth** _____

Street Address (if different from above) _____

City _____ **State** _____**Zip** _____**Employer**_____

LEGAL GUARDIAN(NEED TO HAVE PROOF OF GUARDIANSHIP)

Last Name _____ **First** _____ **MI**_____

Social Security # _____**Date of Birth** _____

Street Address (if different from above) _____

City _____ **State** _____**Zip** _____**Employer**_____

ACCT # _____

Emergency Contact

Name_____**Phone** _____

Address (if different from above) _____**Relationship** _____

INSURANCE INFORMATION

Primary Insurance Information (MUST BE FILLED OUT COMPLETELY)

Name of Insurance _____

Insurance Company Address _____**Phone #** _____

Subscriber's Name _____**Relationship to Patient** _____

Subscriber's SS # _____**Date of Birth** _____

Subscriber's Employer _____

Insured's ID # _____**Group #** _____

Secondary Insurance Information (MUST BE FILLED OUT COMPLETLEY)

Name of Insurance _____

Insurance Company Address _____**Phone #** _____

Subscriber's Name _____**Relationship to Patient** _____

Subscriber's SS # _____**Date of Birth** _____

Subscriber's Employer _____

Insured's ID # _____**Group #** _____

***If you have more than two insurances, please list them here and give the card to the receptionist for copying. Any insurances not received at time of appoinment will not be billed unless received via writing/phone and card copy within 45 DAYS. If you have a Secondary or even Tertiary insurance that does NOT mean there may not be a patient balance. If you get a bill from us and think it may be in error, please contact us as soon as possible so that we can correct it. If you get RETROACTIVE coverage after your appointment, including Medicaid plans, you MUST contact us within 45 days to allow time for billing otherwise you may be responsible for the bill.**

_____

OTHER INSURANCE **Initials**

Insurance Authorization & Assignment

Family Allergy & Asthma Care Consultants, LLC.
Shankar Lakhani, M.D.

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above-named if applicable. I am responsible to check my benefits and in network status of this provider. I understand that I am responsible to obtain and provide authorizations that may be required by my insurance company for my treatment. I understand that copays are due at time of shot and it is my responsibility to provide any and ALL insurance in effect at my time of service, failure to do so may result in a balance to myself regardless of commercial or Medicaid status.

I certify that the information that I have reported with regard to my insurance coverage is correct and further authorize the release of any information, including medical information, to my insurance company and/or collection agencies, if necessary, in order to determine insurance benefits to which I may be entitled. Past due accounts will be placed with a collection agency. You will be responsible for all costs of collection which may include collection fees, attorney fees, and any other fees charged by the collection agency including but not limited to a fee for partial payment made on the past due account. This authorization does not expire. Any changes must be given in writing. This authorization may be revoked by either myself or my insurance company at any time in writing.

PRINT NAME_____ ACCT# _____

X_____

Patient Signature (or Legal Guardian if under 18 years of age) Date

RELEASE OF INFORMATION(OPTIONAL)

***Please list name and DOB of any persons with whom we may discuss your medical information with:**

_____

Name DOB Phone# **Initial**

_____

Name DOB Phone# **Initial**

*****Please list name and DOB of any persons that you give permission to bring the patient for treatment: (Under 18 years of age / including administration of shots)**

_____

Name DOB Phone# **Initial**

_____

Name DOB Phone# **Initial**

***I understand that I must fill out new registration or notify in writing to remove any of the above persons_____ **(Initial)**

Electronic RX Waiver(REQUIRED)

********I _____**AGREE** or _____**DISAGREE** that Family Allergy and Asthma Care Consultants, LLC may use electronic means to send my prescriptions to the pharmacies I have selected. _____ **(Initial)**

********I **give consent** for Family Allergy & Asthma to **obtain** my prescription history from my pharmacies/physicians electronically. _____ **(Initial)**

NAME OF YOUR PHARMACY_____
PHARMACY ADDRESS_____

Acknowledge of Receipt of Notice of Privacy Practice

I, (patient name – please print) _____,
have received a copy of Family Allergy & Asthma Care Consultants, LLC. Notice of Privacy practices. This may also be obtained in PDF format at anytime on our website faacconline.com.

_____ _____
Patient Signature or Legal Rep **Relationship to Patient**

_____ _____
Date **ACCT#**

Family Allergy & Asthma Care Consultants, LLC. **May leave a message** on my answering machine regarding results of lab test. _____YES _____ NO