Allergy, Asthma & Clinical Immunology
FORT WORTH ALLERGY AND ASTHMA ASSOCIATES
www.fwallergy.com
4200 S. Hulen Suite #230 ◆ Fort Worth, Texas 76109-4924 ◆ 817-315-2550 ◆FAX 817-732-4660
Susan R. Bailey, MD., PA   Andrew D. Beaty, M.D., PA   Robert J. Rogers, M.D., PA

New Patient Information

Welcome to Fort Worth Allergy & Asthma Associates!

Your appointment is with Dr.____________________ on ____________________ at _____________.

If you are paying for this visit without insurance, your visit cost may range from $165-$800, depending on the need for and extent of allergy testing that may be done during your visit. You will be able to discuss your testing options with your doctor at the time of your visit. Payment is expected at the time of your appointment. If you need to arrange a payment plan, please contact us prior to your visit to do so.

Your health insurance coverage is a contract between you and your insurance company. If your insurance plan requires you to have a referral, it is **your responsibility** to obtain the referral **prior to your appointment**. If a referral is required, please contact your primary care physician's office as soon as possible, as it may take up to a week to process the referral. If you come for an office visit without a current referral, you will be asked to reschedule your appointment or to pay out of pocket for your visit.

You will need to bring your insurance card at the time of your visit. If your insurance plan has a co-pay, you will need to be aware of that amount. For some insurance plans, office visit co-pays are higher for specialist visits (**we are specialists**) than for primary care visits. We will collect your co-pay at the time of service. If you have not met the deductible for your insurance or co-insurance fees apply, we will collect payment for the services provided. Please read the attached financial policy carefully, and feel free to ask our staff if there are any questions.

PLEASE DO NOT MAIL THESE FORMS BACK TO THE OFFICE. YOU SHOULD COMPLETE THE FORMS AT HOME AND BRING THEM TO US AT THE TIME OF YOUR APPOINTMENT.

IF YOUR FORMS ARE NOT COMPLETED AT THE TIME OF YOUR APPOINTMENT, IT MAY BE NECESSARY FOR YOU TO RESCHEDULE. PLEASE ARRIVE EARLY TO COMPLETE YOUR PAPERWORK IF YOU HAVE NOT DONE SO PRIOR TO ARRIVAL.

Please do not hesitate to call us at (817) 315-2550 if you have any questions. We look forward to meeting you.

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Appt Date _______

Doctor _________

PATIENT'S NAME (last)____________________________(first)____________________(MI)

ADDRESS____________________________________CITY_________________ST____ ZIP_______

HOME PHONE_________________WORK___________________CELL_________________________

SOCIAL SECURITY#__________________________OCCUPATION____________________________

BIRTHDATE__________________SEX__________MARITAL STATUS__________________________

EMAIL_____________________________REFERRING PHYSICIAN____________________________

Insurance Information (must be completed for all commercial, Medicare, and Medicaid insurance)

IF PATIENT IS NOT THE INSURANCE HOLDER, MUST PROVIDE ALL INFORMATION RELATING TO PRIMARY INSURED

INSURANCE COMPANY______________________________________REFERRAL REQUIRED? YES/NO

INSURED PERSON____BIRTHDATE___________________

SUBSCRIBER ID#__________________________________GROUP____________________________

INSURED SOCIAL SECURITY#__________________________ EMPLOYER______________________

RELATIONSHIP TO PATIENT (if not self)____

PARENT/GUARDIAN____BIRTHDATE_________________

ADDRESS__________________________________CITY________________ST______ZIP________

EMPLOYER________________________________WORK PHONE___________________________

SOCIAL SECURITY NUMBER OF RESPONSIBLE PARENT/GUARDIAN____________________________

RELATIVE NOT LIVING WITH YOU (NAME)________________________RELATIONSHIP______________

ADDRESS____PHONE____________________

I HAVE RECEIVED AND UNDERSTAND THE PAYMENT POLICIES OF FORT WORTH ALLERGY AND ASTHMA ASSOCIATES. SIGNATURE(parent if minor)___________________________________DATE___________