Allergy, Asthma and Immunology

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Paul M. Mauriello, M.D. ***Nicholas A. Orfan, M.D.***

Patient Information – Please Print

Mr. ____ Miss ____ Mrs. ____ Ms. ____ Female ____ Male ____

Patient's Last Name	First	M.I.	
Age	Date of Birth	Street Address	E-Mail Address
City	State	ZIP Code	Social Security Number
Home Phone	Business Phone	Patient's Occupation	
Employers Name	Address		
Person to notify (name and address of relative or friend not residing with you)	Phone		
Primary Care Physician	Address	Phone	

Financial Responsibility

Last Name	First	M.I.	Social Security Number	Relationship to Patient
Street	City	State	ZIP Code	
Home Phone	Business Phone	Employer	Address	

Insurance – Please present your insurance card to the receptionist

Name of Primary Insurance Company	Address		
Policy or Identification Number	Group Number	Effective Date	Policyholder's Name
Social Security Number	Date of Birth	Place of Employment	
Name of Additional Insurance Company	Address		
Policy or Identification Number	Group Number	Effective Date	Policyholder's Name

I consent to medical treatment by Drs. Mauriello and Orfan and their staff for the care of the above patient.

I further authorize and request that insurance payments be made directly to Drs. Mauriello and Orfan for insurance companies we agree to submit to.

I have read this form and fully understand the consent for treatment, financial responsibility, release of medical information and insurance authorization.

____ *Signature*

_______________________ *Date*

Policy continued on the back of this form

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of my medical records, if necessary.

I understand that payments of charges incurred; co-pays, co-insurance deductibles and non-covered services are **DUE AT THE TIME OF SERVICE** unless other definite financial arrangements have been made prior to treatment.

I agree to pay all reasonable attorney fees and collection costs in the event of defaults of payment of my charges.

I understand that there will be a $5.00 service fee if there is a need to bill for unpaid balances.

I understand there will be a $25.00 service fee if co-pay/co-insurance is not paid at time of service.

I understand there will be a $20.00 service fee for returned checks.

I acknowledge full financial responsibility at the time services are rendered for care not authorized by my HMO/POS plan.

I accept full financial responsibility if incorrect insurance information is provided that results in a denial of claims.

I understand the staff will assist in dealing with my insurance company, but it is my responsibility to know and understand my own insurance.

Please initial to verify you have read and understand these policies. ________

We appreciate the confidence that you have expresses in selecting us as your physician. It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstanding at a later date. If you have any questions about our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

Drs. Paul M. Mauriello and Nicholas A. Orfan