Michael J. Reid MD & Janel Liverato, PA-C
369 Pine St. Suite 422
San Francisco, CA 94104
Phone 415-788-4128/Fax 415-788-4180

NEW PATIENT REGISTRATION RECORD

Patient Name:____ Social Security #:_______________________

Date Of Birth:___________________ Marital Status: _____________________

Street Address:____ City:_________________ State_____ Zip_______

Home Phone:_______________________ Work Phone:____________________ Cell Phone:________________

Insurance Company:___________________________ ID: #_____________________ Plan/Group#:_____________

****BEST EMAIL ADDRESS TO REACH YOU**____**
(Email will be used for appointment reminders or if we cannot get in touch with you by phone.)

****If the patient's insurance is under either their spouse's name or parent's name; please fill out the information requested below for proper billing.****

Name of person that insurance is under:_________________________________ Date of Birth___________________

Card Holder's SSN_______________ Best number to contact:_________________________________

How did you hear about our office: Dr.___________________ Web:_____________ Patient________________

Employer:_______________________________________ Occupation:___________________________

Employer Address:____

Emergency Contact:_________________________________ Phone:______________________________

Address:____ Relationship:__________________________

FINANCIAL POLICY

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Welcome to our allergy & asthma clinic! We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care.

Insurance Coverage- All patients are ultimately responsible for their own bill and a clear understanding of their insurance policy. Patients who have health care coverage are responsible for providing the office with complete and accurate information regarding their insurance. It is the patient's responsibility to understand the terms of their insurance coverage. This includes but is not limited to: knowing what services are covered (allergy skin testing, etc.), where services can be performed (labs), that their provider is in network, their deductible, co-payment, co-insurance (if applicable), obtaining required referrals. We can give you an **ESTIMATE** of what your costs will be, however we strongly suggest you contact your insurance company to verify your part of the expense. We are not responsible for the difference between the estimates we are given by your insurance company and the final payment of the claim. Patients are liable for payment of all medical services, including those not covered by insurance.

Fees and Services Provided- Charges for services provided are subject to change without notice. Each patient's insurance coverage and financial situation is different. If a patient has a concern regarding what our charge for a service is, it is the patient's responsibility to ask prior to the service being performed. Please be advised that in most cases there will be separate charges for each service provided. There will be a charge for the physician's evaluation and then a charge for any other service performed. This may include but is not limited to allergy skin testing and breathing tests, etc. Some services may be performed more than once, for example allergy skin testing is charged per scratch test. The number of skin tests performed can greatly affect the charge from a few dollars to hundreds of dollars.

Self-Pay patients- Patients without health coverage are expected to pay their bill in full at the time of service. We offer a discount only if the total bill is paid at the time of service.

Deductibles/Co-Pays/Co-insurance- Any co-payments required by your insurance company are due at the time of service. We also ask that a portion of your deductible be paid at the time of service, depending on what services are performed. If you have a co-insurance, that portion of your bill will be mailed to you.

Missed Appointments- We understand that occasionally you may have to miss your appointment. We ask that you call to cancel your appointment at least 24 hours in advance, which allows us to use that time for another patient. No-shows or appointments cancelled less than 24 hours in advance will result in a $75.00 cancellation fee.

Medical Records Fee- We are willing to assist patients who require copies of their records. Due to the time and printing involved, there is a $20.00 charge to copy your medical records.

Checks Returned for Insufficient Funds- There is a $25.00 fee for checks returned for insufficient funds.

Patient/Guardian Signature ____

Date:_______________________________