# ALLERGY ASSOCIATES OF SOUTH FLORIDA
# CLIVE E. ROBERSON, M.D.
# WILLIAM F. TUER, M.D.

PATIENT NAME:_____
LAST FIRST MIDDLE
PATIENT'S SOCIAL SECURITY#_____ DOB:_____

MARITAL STATUS – S / M / W / D SEX: MALE_____FEMALE_____

MAILING ADDRESS: _____

OTHER ADDRESS, PO BOX & UP NORTH: _____
_____

HOME TELEPHONE: _____**CELL**:_____

WORK: _____ UP NORTH #_____

PRIMARY LANGUAGE: _____

PHARMACY PHONE NUMBER: _____

INS: _____2ND INS_____

PRIMARY INSURED
NAME_____

DOB: _____ SS#_____

PLACE OF EMPLOYMENT: _____PHONE#_____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ _____

PHONE # _____

**PRIMARY PHYSICIAN**: _____**PHONE #**_____
IN CASE OF EMERGENCY, PLEASE NOTIFY: _____
PHONE # _____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on all sides of this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

_____ _____
SIGNATURE – IF MINOR – PARENT SIGNATURE DATE

# PAY DIRECT AUTHORIZATION FORM

**PATIENT NAME:** _____

Assumption of responsibility: The undersigned agrees, whether he signs as agent or as patient, that in consideration of services to be rendered to the patient named above he hereby obligates himself, assumes financial responsibility and agrees to pay upon demand to above named PROVIDER all charges for such services and incidentals incurred by said patient. Should the account be referred to an attorney for collection expenses. The undersigned understands that all bills are payable upon presentation and that he and not the insurance company is responsible for the payment of all services.

Assignment of Insurance Benefits: I / We hereby guarantee payment of all charges incurred for the account of the above said patient from date of first treatment until discharge or termination of treatment, and hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including major medical benefits, insurance sick benefits or injury benefits payable because of liability of third party by any party or organization, and so forth, payable to or for the above said patient be paid in full.

Pre-Existing Condition Clause: Many insurance companies contain a clause, which precludes coverage for “pre-existing conditions.” The starting date of your disease, from the standpoint of the insurance company, will coincide with the time that your symptoms began. Therefore, you should take careful note of this when you fill out the medical form. If your contract negates payment because it excludes your pre-existing condition or other reasons, you will be held responsible for the bill.

Authorization to release or request information: The undersigned hereby authorizes said PROVIDER to release sociological and medical information officially acquired in the course of examination and treatment for the purposes of being for insurance benefits and other financial coverage, or for medical data necessary for my examination or treatment.

I HAVE READ, UNDERSTOOD AND APPROVED ALL OF THE ABOVE.

SIGNATURE: _____ DATE: _____

RELATIONSHIP: _____SELF

_____PARENT / GUARDIAN

_____ OTHER

# INSURANCE COMPANIES REQUIRING REFERRALS
# HMO, POS, EPO

****IF YOU DO NOT HAVE AN HMO, POS, EPO PLAN DO NOT SIGN THIS FORM!!!!****

**MANY INSURANCE COMPANIES REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN BEFORE SEEING A SPECIALIST. IT IS YOUR RESPONSIBILITY TO GET THE REFERRAL AND MAKE SURE THAT WE RECEIVE IT PROIR TO YOUR VISIT. THIS REFERRAL ASSURES US THAT THE INSURANCE COMPANY WILL PAY FOR THE VISIT OR OTHER SERVICES SUCH AS SHOTS OR EXTRACTS. THEREFORE, IF YOU DO NOT HAVE THER REFERRAL, PAYMENT FOR THE SERVICES PROVIDED WILL BE YOUR RESPONSIBILITY. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR BILLING DEPARTMENT. (561) 655-4450.**

**I HAVE READ, UNDERSTOOD AND APPROVED ALL OF THE ABOVE.**

**SIGNATURE: _____ DATE: _____**

**RELATIONSHIP: _____SELF**

**_____PARENT / GUARDIAN**

**_____ OTHER**

# CLIVE E. ROBERSON, M.D
# WILLIAM F TUER, M.D

**ALLERGY ASSOCIATES OF SOUTH FLORIDA**

# TREATMENT, LIABILITY WAIVER & PAYMENT AUTHORIZATION

**I HEREBY AUTHORIZE DR ROBERSON AND ANY OTHER PHYSICIAN, AND NURSE PRACTIONERS TO ADMINISTER MEDICAL CARE AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT. I AGREE TO WAIVE ANY MEDICAL LIABILITY TO THE PHYSICANS LISTED ABOVE.**

**I FURTHER AUTHORIZE MY INSURANCE COMPANY OR OTHER PARTIES TO PAY DIRECTLY TO DR ROBERSON'S PRACTICE FOR MY MEDICAL EXPENSES AS SPECIFIED UNDER THE TERMS OF MY TREATMENT. IN MAKING THIS ASSIGNMENT, I ALSO AGREE THAT, WHEN LEGALLY ACCEPTABLE, ANY OF MY ACCOUNT BALANCE THAT IS NOT COVERED BY MY INSURANCE AFTER THE ASSIGNMENT GIVEN BY THE INSURANCE COMPANY, I WILL BE RESPONSIBLE FOR THE DIFFERENCE. PHOTO COPIES OF THIS DOCUMENT WILL NOT BE ACCEPTED OR VALID.**

_____ _____

**SIGNATURE OF PATIENT OR GUARANTOR** **DATE**

_____

**RELATIONSHIP TO PATIENT**