Illinois Allergy & Asthma Specialists

Dr. Amishi Singal Murthy & Dr. Vivian Chou

COS Building • 2500 Ridge Ave • Suite 211A • Evanston, IL 60201
3000 Halsted Street • Suite 724 • Chicago, IL 60657
Phone: (847) 328-7909 • Fax: (847) 328-7919
www.ilallergyasthma.com

New Patient Registration Form

Date: _____Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Sex: _____ Marital Status: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: Primary: (___) _____-_____ Secondary: (___) _____-_____ Tertiary: (___) _____-_____ Preferred: _____
OK to leave message regarding normal test results on voice mail? Please check one: ◯ Yes ◯ No

Email Address: _____
*Please refer to *Enrollment in Online Patient Health Record Access and Email Communication Authorization* for details.

If minor, name of parent/guarantor: _____ Relation: _____

Emergency contact:
Name: _____ Relationship to patient: _____ Phone: (___) _____-_____

Preferred pharmacy: _____ Phone: (___) _____-_____
Address: _____City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone: (___) _____-_____
Address: _____City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: (___) _____-_____
Address: _____City: _____ State: _____ Zip: _____

PRIMARY Insurance:

Insurance Company: _____ Subscriber ID #: _____ Group #: _____

Billing Address (if different from above): _____ City: _____State: _____ Zip: _____

Insured's name: _____ Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____ Employer's phone: (_____) _____-_____

Employer's Address: _____City: _____ State: _____ Zip: _____

Co-Pay amount: $_____

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SECONDARY Insurance (if applicable):
Insurance Company: _____ Subscriber ID #: _____ Group #: _____

Billing Address (if different from above): _____ City: _____State: _____ Zip: _____

Insured's name: _____ Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____ Employer's phone: (_____) _____-_____

Employer's Address: _____City: _____ State: _____ Zip: _____

Co-Pay amount: $_____

Authorization for Medical Care, Payment and Release of Information
I, the undersigned, hereby authorize the physicians of Illinois Allergy and Asthma Specialists, SC to render medical evaluation and treatment for the named patient. I authorize payment of medical benefits for any services furnished to me or to the patient by Illinois Allergy and Asthma Specialists, SC. I understand that I am responsible for any amount not covered by my insurance (i.e. plan exclusion, no referral on file, out of network, coverage terminated, high deductible, etc.). I authorize Illinois Allergy and Asthma Specialists, SC to release any information acquired in the course of my evaluation or treatment to any provider, other party, or my insurance company or their agent for the purpose of treatment, payment, or practice operations.

Cancellation and Delinquent Account Policy
To best service the schedules of our patients: for office visits canceled less than 24 hours in advance, or failure to keep an appointment, patients may incur a $50 charge. All accounts not paid within 60 days will be forwarded to a collection agency.

Signature: _____ Date: _____

Printed Name: _____ Patient's Name: _____

Credit Card type: ◯ Visa ◯ MasterCard ◯ AMEX (online payment only) ◯ Discover (online payment only)

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

I hereby acknowledge receipt of the medical services, authorize IAAS to bill the above credit card for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in your agreement with the credit card issuer.
I authorize IAAS to process the above credit card as "card on file." I will be notified when my credit card is charged. I understand this authorization will remain in effect until the expiration of the credit card account. Patient also may revoke this form by submitting a written request to the medical practice. I have read and understand the financial policy of this medical office and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without prior written notice.
_____ Initial

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Enrollment in Online Patient Health Record Access and Email Communication Authorization

Illinois Allergy and Asthma Specialists (IAAS) is inviting you to access your patient health record online. By agreeing to the terms below, you will have access to your health record, including certain lab results, online. When you enroll, you will receive an email inviting you to create an online account. You will also receive a PIN from our office, which you will need to sign up. You will not receive unwanted email/spam from IAAS. In addition, you may also choose to communicate via email with your physician. Please see below regarding our policies for email communication.

- Email should be used for NON-EMERGENCY purposes only.
- Your doctor may not be checking email frequently and may take 48-72 hours to respond to your emails. Emails will not be answered over the weekends, holidays, or after business hours. Regular business hours are from 9 am to 5 pm, Monday through Friday.
- For any emergencies, please call 911.
- For any urgent issues, please call the office at 847-328-7909.
- Email communications from your physician may NOT be encrypted, and the security of such emails cannot be guaranteed.
- All email communications and pictures will be filed in your or your child's permanent medical record.
- Please inform this office in writing if you change your email address.

I hereby give consent to my physicians, Dr. Amishi Singal Murthy and Dr. Vivian Chou, and the staff of Illinois Allergy and Asthma Specialists, to communicate with me via email. I understand and agree to the above policies regarding email communication. I also wish to enroll for online access to my patient health record online.

Current email address: _____

Printed name of patient: _____

Signature of patient/parent/guardian: _____ Date: _____

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Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Illinois Allergy and Asthma Specialists to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available online at www.ilallergyasthma.com

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Communication with Family Members/Parents/Others:

We take patient confidentiality very seriously. In addition to yourself or your child, please specify another person(s) with whom we may discuss your test results/health information, if so desired

◯ I want my test results/healthcare information reported only to me

◯ Dr. Chou and Dr. Murthy have my permission to speak with the following individuals only (Please include name/relationship and telephone number):

1. _____
2. _____
3. _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____