Tonny Tanus, MD
Eric J. Boren, MD
Board Certified Adult & Pediatric

www.kernallergy.com

2121 17th Street
Bakersfield, CA 93301
(661) 327-9693
FAX: 327-0749

443 W. Morton Suite B
Porterville, CA 93257
(559) 782-8578
FAX: 782-8594

1519 Garces Hwy, 107
Delano, CA 93215
(661) 721-8832
FAX: 721-8319
Monday 2-6pm

KERN ALLERGY MEDICAL CLINIC, INC. FINANCIAL/OFFICE POLICY:

Our goal is to provide outstanding allergy care for our patients as well as foster good physician/staff-patient relationships. Please do not hesitate to ask a staff member if you have any questions.

1. I understand that it is my responsibility to provide my correct and current insurance information. Otherwise I will be liable for any and all charges.

2. I am responsible for all Co-payments, Deductible, and Co-insurance due at the time of service.

3. It is my responsibility to understand my insurance benefit plan. It is my responsibility to know if a written referral or authorization is required for office visits and procedures.

4. Not all services provided by our office are covered by all insurance plans. Any service determined to not be covered by my plan will be my responsibility.

5. If our physicians do not participate in your health plan, payment is expected in full at the time of service.

6. We require **24-hour notice** for cancelling any appointments:
   There is a $30 charge for missed office visits
   There is a $50 charge for missed lung function tests (PFTs) or skin tests

7. We require that a current copy of your personal credit card or the health savings account debit/credit card remains on file. Our software has been thoroughly vetted according to strict data retention rules and is HIPPA compliant.

8. Patient balances are billed after we receive your insurance plans explanation of benefits (EOB) with your balance owed. Your payment is due within 30 days from the date on your statement. If you do not pay your balance within 60 days, we will automatically charge your personal credit card on file for the amount due.

9. A $50 fee will be charged for any checks returned, plus any bank fees incurred.

Initial___________

Continue on back side……

10. For medical records there will be a fee of $15.00 for one report and $35.00 for complete chart. This fee is due at the time of request.

11. If you or your child has forms to be completed by your physicians, there will be a charge of $15 per page. Payment is due when the forms are dropped off. We typically have a 3-5 business day turnaround time.

TERMS AND CONDITIONS

I agree to pay Kern Allergy Medical Clinic, Inc. for all charges incurred, which are not promptly reimbursed by the patient or the insurer. As any direct billing by Kern Allergy Medical Clinic, Inc. to the insurance company is merely an accommodation, I will be primarily and ultimately responsible for payment.

If my account goes over 60 days, I agree to have my credit card charged to pay any balance on my account that is over 60 days.

_____Visa _____MasterCard _____American Express Account #_______________________________________

Security Code (3 digit code)______________Expiration Date ____

Name of Card Holder ____________________________________

If this account is assigned to an attorney for collection and/or suit the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure if portions of the patient's record.

I further consent to and direct my insurance carrier, third party liability carrier, employer, or any person possessing pertinent information to release such information upon demand. A copy of this authorization shall serve as on original. I, on behalf of the patient and/or individual, accept and agree to these terms and condition

I have read and understand this office financial policy and agree to comply and accept the responsibility of any payment that becomes due as outlined.

PatientName(s):____

Responsible party (guarantor) name if different and relationship:

____

Responsible Party/Patient Signature:

____

Date: ______________________

EB 12/14

KERN ALLERGY MEDICAL CLINIC, INC
Tonny Tanus, M.D. Eric J Boren, M.D
New Patient Information
Please Print

Patient's Name:____SS#____________________

Age:________ DOB:____/____/_____Gender: M_____F _____ Marital Status: M____________ S_____W_____D_____

Address:____
City State Zip Code

Home Phone#(____)____________Work#(____)____________ Cell#(____)____________

Email Address: ______________________________Pharmacy_____________________________________

Language:________________ Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other ________

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other or Undetermined

Guarantor's Name:___________________________SS#____________________DOB:_____/____/_____
(If not Patient)

Place of Employment:____

Primary Insurance Company__________________________Policy#__________________Group#____________

Name of Insured:__________________________________SS#____________________ DOB:____/____/_____

Address of Insured:____
City State Zip Code

Home Phone#(______)____________ Work#(_____)________________ Cell#(_____)____________

Secondary Insurance Company________________________Policy#__________________Group#____________

Name of Insured:__________________________________SS#____________________DOB:____/_____/_____

Address of Insured:____
City State Zip Code

Home Phone#(______)____________Work#(______)________________Cell#(______)____________

Name of Emergency Contact:________________________________Phone #_____________________________

Primary Physician:__________________________________Referred by:______________________________

OFFICE POLICY:

1. Medical care will not be provided over the phone. Lab or procedure results and antibiotic requests will be discussed at office visits only unless previously arranged with the doctors.

2. No medications will be refilled on weekends or holidays. The office answering service will be used for emergencies only when you cannot wait until the next business day. Go to an ER or call 911 immediately for any severe allergic reactions or asthma exacerbations.

________________________________ ________________________________ ________________
Member or Member's Legal Guardian (Print) Member or Member's Legal Guardian (Sign) Date