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

Tonny Tanus, MD
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Darryl Altavas, FNP
Board Certified Adult & Pediatric

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FAX: 327-0749

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(559) 782-8578
FAX: 782-8594

1402 Jefferson St.
Delano, CA 93215
(661) 721-8832
FAX: 721-8319

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 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.

7. 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.

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

9. 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.

10. 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.

Initial_____

Continue on back side……

TERMS AND CONDITIONS

I agree to pay Kern Allergy Medical Clinic, Inc. for all charges incurred, which are not promptly reimbursed by 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. After credit card number is entered, the number will be blacked except for the last 4 digits.

_____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 of 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 conditions.

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.

Patient Name(s): _____

Responsible party (guarantor) name if different and relationship:

_____

Responsible Party/Patient Signature:

_____

Date: _____

EB 01/17

APPOINTMENT POLICY

I understand that this is the appointment policy for the office of Kern Allergy Medical Clinic.

I will be charged:
- $30 fee for any missed No-Show appointments
- $50 fee for any missed procedure appointment (Testing or Pulmonary Function Test)

To avoid a fee; appointments need to be cancelled within **24 hours** of my scheduled time. If I have two appointments scheduled on the same day I am subject to a $30 fee and a $50 fee for both appointments for a total of $80.00. We do understand emergencies, illness, etc. If you are not able to call the office that day please call us as soon as you are able to.

The fee is due before your next scheduled appointment. If you have two No-Show fees totaling $60max it must be paid before another appointment can be scheduled.

I am aware I can leave a detailed message on our after-hours answering service if I am not able to keep my appointment. Please make sure to leave patients name, D.O.B, appointment time, and reason for your cancellation. Our Receptionist will check messages each business day. Failure of not leaving a message will results in a No-Show fee. Otherwise, we assume the appointment will be kept with your physician.

Keep in mind it is a courtesy call to remind you of your appointment. It is ultimately your responsibility to write down and keep track of your appointments.

These fees are your responsibility and not payable by your insurance company. Also patients that have multiple no shows and cancellations may be dismissed from the practice.

_____

Print Patient/Guardian Name

_____ _____

Patient/Guardian Signature Date

EB 1/17

Patient Name: _____
D.O.B:_____

Health History

Please check ☑ all conditions you ***currently*** have or have had in the ***past***:

☐ Asthma
☐ Anemia
☐ Anxiety
☐ Autoimmune Disorder
☐ Blood Transfusions
☐ Brain Tumor
☐ Bipolar Disorder
☐ Cirrhosis
☐ COPD
☐ Colon Cancer
☐ Coronary Heart Disease
☐ Cohn's Disease
☐ Depression
☐ Diabetes- Type 1
☐ Diabetes- Type 2
☐ Eczema
☐ Fibromyalgia
☐ GERD / Acid Reflux
☐ Hashimoto's Thyroiditis
☐ High cholesterol
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Hypertension
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ HIV / Aids
☐ Lupus
☐ Migraines
☐ Neuropathy
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Varicose Veins
☐ Other: _____

Family History

Please check ☑ any medical conditions that First Degree relatives have (e.g., Mother, Father, siblings)

☐ Anemia
☐ Arthritis
☐ Anxiety
☐ Birth defects
☐ Bleeding disease
☐ Breast Cancer
☐ Bipolar Disorder
☐ Crohn's Disease
☐ Colon cancer
☐ Depression
☐ Diabetes Type 1 or 2
☐ Heart disease
☐ Hypertension
☐ High cholesterol
☐ Kidney disease
☐ Lung/Respiratory disease
☐ Migraines
☐ Osteoporosis
☐ Seizures
☐ Severe allergies
☐ Stroke
☐ Thyroid problems
☐ Angina
☐ Cervical Cancer
☐ Growth/Development
☐ Headaches
☐ Lung Cancer
☐ Melanoma
☐Ovarian cancer
☐ Psychiatric Cancer
☐ Uterine Cancer
☐ Weight disorder
☐ MS
☐ Endometriosis
☐ Other: _____

For any of the above conditions checked, please state the relationship:

If you are 13 years of age and older please answer the following question. Parents please answer this question for any smokers in the home for minors.

Tobacco Use: ☐ Never ☐ Former Smoker/ Quit_____ ☐ Yes #cigs_____/day
Alcohol Use: ☐ Never ☐ occasionally ☐ yes - amount per day _____

1. List any over-the-counter and prescribed medications you are currently taking:

Name:	Dose:

2. Please List any surgeries or hospitalizations you have had:

3. What do you have in your home? Check all that apply

Please state whether pet(s) are *indoor* or *outdoor*

- ☐ Dog(s)
- ☐ Cat(s)
- ☐ Cattle
- ☐ Rabbits
- ☐ Horse(s)
- ☐ Other_____
- ☐ Tile
- ☐ Carpet
- ☐ Linoleum
- ☐ Laminate
- ☐ Wood
- ☐ A/C
- ☐ Swamp Cooler

4. Please list any allergies to medication:
