

ALLERGY & ASTHMA CARE CENTER

2510 Limestone Parkway

922 Gainesville Hwy. Suite 115

Gainesville, GA 30501

Buford, GA 30518

Phone (770)534-9933 Fax (770)534-8999

Insurance Information

Patient's Name: _____

PRIMARY INSURANCE:

Full Name of Insured: _____ DOB: _____

SS# _____ Relationship of Patient to Insured: _____

Address/Phone number of Insured person (if different from patient) _____

Primary Insurance Company Name: _____

Policy # _____ Group# _____

SECONDARY INSURANCE:

Full Name of Insured: _____ DOB: _____

SS# _____ Relationship of Patient to Insured: _____

Secondary Insurance Company Name: _____

Policy # _____ Group # _____

Address/Phone # of Insured Person(if different from patient): _____

Do you have Medicare? Yes No Medicare #: _____

Do you have Medicaid? Yes No Medicaid #: _____

(If current Medicaid card is not furnished at the time of service, or if you have exceeded the allowed number of doctor visits per year, you are expected to pay for services rendered)

If you have insurance coverage, we ask that you pay the amount not covered by insurance at the time of your visit. For example, if your coverage is 80%, please pay the 20% of the balance at the time of your visit. All Co-Pays and Deductibles are due at the time of service. If your insurance does not respond within 30 days after your claim is filed, then payment is your responsibility. If you have any questions, please ask.

I authorize the release of any information necessary to process claims and direct payment to the Allergy & Asthma Care Center, the office of Dr. Andy Nish. I understand that I am responsible for ALL charges, regardless of insurance coverage. If the patient is a minor, financial responsibilities lie with the parent/guardian bringing the child.

Patient, Parent/Guardian Signature

Date