GENE A. DEVORA, M.D.
Allergy & Immunology
PATIENT INFORMATION

NAME ______________________________ BIRTH DATE ________________ AGE ________________

ADDRESS ______________________________ CITY ________________ ZIP ________________

SSN ______________ SEX ________ MARITAL STATUS __________ HOME PHONE ________________

WORK PHONE ________________ CELL PHONE ______________ PAGER ________________

EMPLOYER ______________________________ FAX # ________________

ADDRESS ______________________________ CITY ________________ ZIP ________________

WHO REFERRED YOU? ______________________________

EMERGENCY INFORMATION

SPOUSE ______________________________ SPOUSE WORK PHONE ________________

RELATIVE ______________________________ RELATIVE HOME PHONE________________

FRIEND ______________________________ FRIEND HOME PHONE ________________

PRIMARY INSURANCE INFORMATION

________ PRIVATE PAY (Cash) ________ PPO ________ HMO ________ MEDICARE ________ OTHER

INSURANCE COMPANY ______________________________

ADDRESS ______________________________ CITY ________________ ZIP ________________

INSURED'S NAME ______________________________ BIRTH DATE ________________

INSURED'S SSN ______________________________ GROUP # ________________

INSURED'S EMPLOYER ______________________________

HOW LONG AT ABOVE EMPLOYER ______________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ______________________________

ADDRESS ______________________________ CITY ________________ ZIP ________________

INSURED'S NAME ______________________________

INSURED'S SSN ______________________________ GROUP # ________________

INSURED'S EMPLOYER ______________________________

PATIENT / RESPONSIBLE PARTY'S AUTHORIZATION

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO PROCESS CLAIM.

I REQUEST THAT PAYMENT OF MEDICAL BENEFITS BE MADE TO DR. LESLIE WEISBERG AND I UNDERSTAND THAT THIS IS AUTOMATIC IN CASE OF HOSPITALIZATION. THIS ASSIGNMENT OF BENEFITS WILL REMAIN EFFECTIVE UNTIL REVOKED BY ME IN WRITING.

PATIENT'S SIGNATURE ______________________________ DATE ________________

GENE A. DEVORA, M.D.
Allergy and Immunology
PAYMENT POLICY

1. We will file insurance for our PPO, HMO and other managed care patients. However, all managed care copayment and/or deductible and coinsurance amounts are due at the time of the service. Any disallowed/uncovered amounts are due from the patient. It is your responsibility to make sure that Gene a. Devora, M.D. is in your managed care network. There will be a $15.00 fee added to your account if the copay coinsurance is not paid at the time of the service.

2. Patients who do not cancel or reschedule their appointment at least 24 business hours prior to their scheduled vist will be charged a fee of **$25.00.** Also, this fee applies to any patients that do not show up for their scheduled appointment. This office will make reasonable attempts to confirm appointments one to two days in advance of the appointment date. Excessive no shows and/or cancellations could be grounds for termination from Plano Internal Medicine Associates.

3. There will be a twenty-five dollar ($25) fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount. Payments will be expected in the forms of cash, money order, Visa or Master Card. If payment is not received by the due date indicated on the bill, then your information will be turned over to the Collin County District Attorney. After receiving a returned check we will no longer accept check payments on any future visits not to exceed five years.

4. For all account balances in excess of 90 days a collection fee of $50.00 will be added to the balance (even if payment delay is due to the insurance company) and the account will be turned over to our collection company. It is ultimately the patient's responsibility to make sure the doctor received payment for service rendered.

5. We accept assignment and will file insurance for our Medicare patients. However, any calendar year deductible amounts (to the extent of the visit amount) are due at the time of service. We will also file secondary insurance after payment from Medicare. If there is no secondary insurance, patient will be billed for any remaining balance.

6. Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims, reductions or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. We will attempt to verify coverage, although that is not a guarantee of payment until your insurance has processed the claim.

7. Personification of Hospital – we must be notified within twenty four (24) hours of any hospital admit so that we may precertify your hospital visit/stay. Failure to do this may result in reduction of benefits. We will not be responsible for any reduction of benefits if this is not done.

8. If any patient is owed a refund, all claims must be processed and paid in full before overpayment is refunded.

9. All patients are required to give their Social Security No. **No Exceptions.** If the insurance policy is through someone other than the patient we will need their Social Security No. as well. This is to ensure payment for services that are rendered by PIMA.

REFERRAL AUTHORIZATION

When referred, it is the patient's responsibility to verify that the physician or facility is in their insurance network. If you are a patient who requires a referral to see Dr. Devora, you must have your referral with you at the time of your appointment, or it must be faxed to our office before you arrive to see the doctor. Any patient without a referral must be rescheduled until the referral is received in our office, or the patient must pay for their visit in full at the time of the appointment. No exceptions will be made.

AUTHORIZATION

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits and hospital stays to Gene A. Devora, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

Patient's Signature ____ Date ____________________