

**LESLIE A. WEISBERG, M.D.**

Allergy and 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 A. 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 \_\_\_\_\_

**LESLIE A. WEISBERG, 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 co-insurance 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 Leslie A. Weisberg, 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 service.
2. 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 the 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.
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, or credit card.
4. 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. Reduction 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.
5. For all accounts that must be sent to a collection agency a \$50.00 fee will be added to those account balances for processing. For all account balances in excess of 90 days past due a late fee of \$50.00 will be added to the balance (even if the payment delay is due to the insurance company). It is ultimately the patient's responsibility to make sure the doctor received payment for service rendered.
6. Precertification 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.
7. If any patient is owed a refund, all claims must be processed and paid in full before overpayment is refunded.

**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. Weisberg, 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 Leslie A. Weisberg, 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 \_\_\_\_\_