

Imtiaz Ahmad MD, MPH



Patient-focused care • Excellence in patient care • Access to innovation

Specializing in:

- Allergy
- Asthma
- Bronchitis
- COPD
- Critical Care
- Emphysema
- Sleep Disorder
- Unexplained dyspnea

Welcome to Allergy Sleep & Lung Care PA! We are happy to have you as our patient. We'll work with you to manage your symptoms and your wellness is our goal. At Allergy Sleep & Lung Care we are specially trained to help you maintain optimum health. Everything we do is driven by a patient care philosophy that is the essence of our practice:

- ***Compassionate, sensitive, patient-focused care:*** Your special needs, concerns, and lifestyle, and those of your family, will guide our treatment planning.
- ***Excellent and cost-effective service:*** The care you receive from us will be on par with the highest national standards. It may include traditional medicine, complimentary treatments, and nutrition and fitness therapies.
- ***Access to innovation:*** We stay up to date with the latest treatment options. If you are eligible, we can provide access to enrollment in clinical trials.

Our role is to assist you and your primary care doctor in evaluating the needs related to any allergy, sleep, and lung conditions. Your comprehensive care may require a team involving several doctors. We'll do our best to help you manage the team to make it as easy and convenient as possible for you.

We promise that you will always be able to reach a doctor with your concerns. If you have any questions, please call us directly at 239-369-5443.

Thank you for trusting us to help maintain your health. Our mission won't be achieved until you feel better. Now you can breathe easier.

Sincerely,

Imtiaz Ahmad, M.D., M.P.H. and  
Allergy Sleep & Lung Care Team



## NEW PATIENT REGISTRATION FORM (PLEASE PRINT)

### DEMOGRAPHIC INFORMATION

Patient Name: \_\_\_\_\_ Sex: M . F  
Last Name First Name Middle Initial

Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
(MM/DD/YYYY)

Mailing Address: (if different from above) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Marital Status: Single . Married . Divorced . Widowed Social Security #: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

How were you referred to our practice? . Yellow Pages . Hospital Referral . Receiving Mail . Newspaper  
. Friend/Relative, if so, name \_\_\_\_\_ Physician, if so, name \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_  
Subscriber #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Claims Address (See Insurance Card) : \_\_\_\_\_  
Guarantor Name (If other than Patient) : \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Guarantor SS#: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_  
(MM/DD/YYYY)

Secondary Insurance: \_\_\_\_\_  
Subscriber #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Claims Address (See Insurance Card) : \_\_\_\_\_  
Guarantor Name (If other than Patient) : \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Guarantor SS#: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_  
(MM/DD/YYYY)

Do you have any other Health Insurance? . No . Yes If Yes, Please indicate below  
Insurance Name: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Relationship To Patient: \_\_\_\_\_ Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
To whom, if anyone, may we release information regarding your health? (Please List Below)  
\_\_\_\_\_  
\_\_\_\_\_

### PHARMACY INFORMATION

Pharmacy Name: \_\_\_\_\_  
Pharmacy Phone #: \_\_\_\_\_ Pharmacy FaX(If Known): \_\_\_\_\_  
Pharmacy Address If Known: \_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with the insurer). I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits either to Allergy Sleep and Lung Care or Intiaz Ahmad, MD (as applicable) who accepts assignments.

I have received notice of this organization's privacy policies

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## FINANCIAL POLICY

Allergy, Sleep & Lung Care PA (ASLC) is dedicated to providing you the most efficient care and service possible. The following is a summary of our financial policy; **your understanding of our financial policy is an essential element of your care and services.** If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our staff.

### ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered, unless other arrangements have been made in advance. This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. ASLC accepts cash, personal check, VISA, and MasterCard. There is a service charge of \$25.00 for returned checks. Patients with an outstanding balance of 30 days overdue must make arrangements for payment prior to scheduling appointments. **Any balance unpaid after ninety days will be turned over to a collection agency.**

### INSURANCE:

ASLC will submit your primary and secondary claims; however, it is important to remember that your insurance is a contract between you and your insurer. Not all services are covered by all carriers. Services which are not covered by your insurance are your responsibility. ASLC is committed to partnering with its patients to resolve insurance payment delays. You may be contacted to assist us in resolving issues with your insurance company. If we experience delays in payment beyond 60 days we will notify you by a statement asking you to contact us immediately so we can resolve any issues and avoid holding you responsible for unpaid claims. **It is your responsibility to make sure we have accurate and pertinent insurance carrier information and billing information.** Any medical expenses not covered by your insurance plan will be billed to you.

### COLLECTIONS / TERMINATION

Balances not paid within ninety days will be reviewed for placement with an outside collection agency. Patients whose accounts are placed with an outside collection agency will be subjected to a \$30.00 processing fee and are terminated from Allergy, Sleep & Lung Care PA. Patients who are terminated from the practice may be reinstated by contacting the Business Office at (239) 369-5443.

### MISSED APPOINTMENTS / LATE CANCELLATIONS

We request that all appointments be cancelled or rescheduled at least 1 business day in advance. There will be a \$20.00 service charge for all missed appointments with out advance notice. This includes office visits, diagnostic testing, and pulmonary rehabilitation.

I have read and understand the Financial Policy and Appointment Policy of Allergy, Sleep & Lung Care PA. I hereby agree to the terms outlined within the policy and have been given the opportunity ask questions.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Patient Name (print) Witness