Alan E. Sheen, MD
3701 Houma Blvd., Suite 101
Metairie, Louisiana 70006
Office (504)-456-1999 Fax (504) 455-0502

Dear Patient:

Welcome to our office! We hope you have a good experience while you are with us.

Since this is your first visit to our allergy office, you should have checked with your insurance company to make sure that allergy visits are part of your contracted plan. If you have not checked, please contact them while you are waiting for your visit with Dr. Sheen.

As a new patient, we want your initial consultation with Dr. Sheen to be thorough, therefore, we have scheduled a sufficient amount time with Dr. Sheen for your appointment. If you cannot make your appointment, please notify our office within a **24 hour** period, otherwise you will be assessed a **$25 cancellation fee**. Should your appointment be cancelled or missed three times in a row, you will be charged a **fee of $25** and placed on a non-schedule list.

Also, you **may** have a **deductible, copay, co-insurance or out-of-pocket** as part of your contracted plan with your insurance company. You need to know if you have met the **deductible or out-of-pocket**. That is the amount that you signed with your insurance for which you are responsible before your insurance company pays. If you have not met the **deductible or out-of-pocket** or if your insurance company states you are responsible for a **copay or co-insurance, you will be responsible for payment at time of service. Once we have filed with your insurance company, and if additional payment is due, you will receive a statement.** This and all bills received from this office are to be paid in full at the time of receipt. We do not do any payment plans. We accept all major credit cards.

Our staff will, also, check with your insurance company to estimate your financial responsibility. The information obtained by our staff shall not constitute an assurance or guarantee of your financial responsibility. Final benefit adjudication is subject to the terms of your contract with the insurance company, including your responsibility for deductibles, copays, co-insurance and/or out-of-pocket amounts, which will be confirmed upon receipt of the Explanation of Benefits (eob) from your insurance company. We strongly suggest you, also, verify your financial responsibility directly with your insurance company.

Thank you for your cooperation. It is always our pleasure to serve you.

Alan E. Sheen, M.D.

By signing below, I confirm I have read this statement, understand and accept responsibility for making complete payments when I receive a bill.

Signed: _____

Date: _____

NEW PATIENT INORMATION

Alan E. Sheen, M.D.
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Welcome To Our Office DATE:

PATIENT'S NAME (PLEASE PRINT)	S.S. #	MARITAL STATUS	SEX	AGE	BIRTHDATE
	- -	S M W D SEP	M F		/ /

STREET ADDRESS PERMANENT OR TEMPORARY	CITY , STATE AND ZIPCODE	CELL PHONE #	HOME PHONE #

EMAIL ADDRESS (IF AVAILABLE)	PREFERRED CONTACT	EMERGENCY CONTACT INFORMATION	ALTERNATE EMERGENCY CONTACT INFORMATION
	CELL HOME WORK	NAME PH#	NAME PH#

PATIENT'S EMPLOYER (IF APPLICABLE)	CITY , STATE AND ZIP CODE	YRS. EMPLOYED	PHONE #

DRUG ALLERGIES (IF ANY)

SPOUSE OR PARENT'S NAME	S.S. #	BIRTH DATE	PHONE #
	- -	/ /	

SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	YRS. EMPLOYED	BUSINESS PHONE #

EMPLOYER STREET ADDRESS	CITY AND STATE	ZIP CODE

SPOUSE'S STREET ADDRESS IF DIVORCED OR SEPARATED	CITY , STATE AND ZIP CODE	HOME PHONE #

PLEASE READ:

ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

PERSON RESPONSIBLE FOR PAYMENT, IIF NOT ABOVE	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE #

BLUE SHIELD (GIVE NAME OF POLICY HOLDER)	EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE

OTHER (WRITE IN NAME OF INSURANCE COMPANY)	EFFECTIVE DATE	POLICY #

MEDICARE #

SPOUSE'S STREET ADDRESS IF DIVORCED OR SEPARATED	CITY , STATE AND ZIP CODE	HOME PHONE #

MEDICARE #	EFFECTIVE DATE	PROGRAM #	COUNTY #	CASE #	ACCOUNT #
	/ /				

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN (S) BEFORE? IF YES, PLEASE INCLUDE THE NAME OF THE PHYSICIAN AND FAMILY MEMBER.

REFERRED BY		

NAME OF PRIMARY CARE PHYSICIAN	STREET ADDRESS, CITY, STATE AND ZIP CODE	PHONE # FAX # (IF AVAILABLE)

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPIDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

NAME OF POLICY HOLDER_____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO_____
FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.
I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATIONS AND CMS OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT (SECTION 1128B OF THE SOOCIAL SECURITY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION) ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE - I HAVE BEEN PRESENTED WITH A COPY OF THIS PROVIDER'S NOTICE OF PRIVACY POLICIES, DETAILING HOW MY INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW. I UNDERSTAND THE CONTENTS OF THIS NOTICE.

SIGNATURE_____ DATE_____

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FINANCIAL & INSURANCE INFORMATION

Patient Name:_____ Patient Social Security Number:_____ Patient Birthdate: _____/_____/_____

Primary Insurance Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Chiropractic Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____ Phone #: _(____)_____ Group # (Plan, Local or Policy #):_____

Insurance Co. Address_____
Street/P.O. Box City State Zip Code

Insured's Name:_____ Insured's Social Security #:_____ Insured Birthday ____/____/____ Relation:_____

Insured's Employer:_____ Employer's Address:_____
Street/P.O. Box City State Zip Code

Secondary Insurance Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Chiropractic Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____ Phone #: _(____)_____ Group # (Plan, Local or Policy #):_____

Insurance Co. Address_____
Street/P.O. Box City State Zip Code

Insured's Name:_____ Insured's Social Security #:_____ Insured Birthday ____/____/____ Relation:_____

Insured's Employer:_____ Employer's Address:_____
Street/P.O. Box City State Zip Code

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be covered service by third party insurers or payers.

_____
Signature Date

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENFITS TO PROVIDER

I, (we), the undersigned patient and/or responsible party hereby jointly authorize this office, its agents/employees to release and disclose all or part of the patients medical records to any entity which is , or may be liable, for all or part of the provider charges.

I, (We), authorize the release and disclosure of any and all of my medical records to any other entity, including but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We), may be entitled. I, (We),authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, (We), authorize and request that payment of any third-party or insurance company benefits be made to this office for any services furnished to the patient. The signatures furnished below shall suffice for all insurance forms and continuing basis.

_____ _____
Signature of Patient Date Signature of Patient Date

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PAYMENT POLICY

Thank you for choosing our practice. We are committed to providing you with quality and affordable healthcare. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions that you may have and sign in the space provided. A copy will be provided to you upon request. Thanks so much for being our patient.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

Insurance - We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission - We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals - If you have an insurance plan with which we are contracted you need a referral authorization from your primary care physician/pediatrician. Referrals are required before an appointment can be scheduled. If we have not received a referral prior to your arrival at the office, we have a telephone for you to use to call your primary care/pediatrician physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Co-payments/Deductibles - All co-payments – deductible and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance - All patients must complete our patient information form before seeing our provider. We must obtain a copy of your picture identification (driver's license, passport etc.) and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage Changes - If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment We accept payment by cash, check, Visa, Mastercard, American Express and Discover.

Patient Statements - If you have an unpaid balance you will receive a statement by mail every two (2) weeks. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to an attorney or collection agency for collections. All payments made go to the oldest outstanding balance.

No Show/Cancellation Fee - Please cancel/reschedule your visits with 24 hours' notice otherwise, a fee of $25.00 will be charged.

Collection Fees - Balances that have not had a payment made within 90 days will be turned over to collections. Guarantor will be responsible to pay all costs of collections including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33 1/3%.

Patient's Name: _____

Responsible Party: _____

Signature: _____

Date: _____

OFFICE USE ONLY: RECEIVED BY_____ DATE:_____

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PLEASE SIGN AND DATE THE ITEMS THAT APPLY

I DO NOT HAVE MEDICAID

SIGNATURE _____ DATE _____

I DO NOT HAVE KIDS MED

SIGNATURE _____ DATE _____

I DO NOT HAVE COMMUNITY CARE

SIGNATURE _____ DATE _____

I DO NOT HAVE MEDICARE

SIGNATURE _____ DATE _____

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PATIENT NAME:_____

ACKNOWLEDGEMENT OF ACCURACY

With my signature, I affirm that all information, including insurance and subscriber information, I have provided the staff of Alan E. Sheen, M.D. is accurate and as thorough as possible.

_____ _____
Signature of Patient/Legal Guardian Date

RECEIPT OF FINANCIAL POLICY

I have received, read and understand the Financial and Insurance Policy.

_____ _____
Signature of Patient/Legal Guardian Date

RECEIPT OF NOTICE REGARDING PRIVACY INFORMATION

I have received, read and understand Alan E. Sheen, M.D. Notice regarding Privacy of Personal Health Information.

_____ _____
Signature of Patient/Legal Guardian Date

ASSIGNMENT OF BENEFITS

I authorize the assignment of any payment by my health insurance plan to my physician.

_____ _____
Signature of Patient/Legal Guardian Date

RECEIPT OF PATIENT'S BILL OF RIGHTS

I have received, read and understand the Patient's Bill of Rights.

_____ _____
Signature of Patient/Legal Guardian Date

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PATIENT'S BILL OF RIGHTS

These rights can be exercised on the patient's behalf by a designated surrogate or proxy decision maker if the patient lacks decision-making capacity, is legally incompetent, or is a minor.

1. The patient has the right to considerate and respectful care.

2. The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current and understandable information concerning diagnosis, treatment and prognosis.

   Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation and the medically reasonable alternatives and their accompanying risks and benefits.

   Patients have the right to know the identity of physicians, nurses and others involved in their care, as well as when those involved are students, residents or other trainees. The patient also has the right to know the immediate and long-term financial implications of treatment choices insofar as they are known.

3. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and doctor's office policy and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the doctor's office provides or transfers to another doctor's office. The doctor's office should notify patients of any policy that might affect patient choice within the institution.

4. The patient has the right to every consideration of privacy. Case discussion, consultation, examination and treatment should be conducted so as to protect each patient's privacy.

5. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the doctor's office, except in the cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the doctor's office will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records.

6. The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.

7. The patient has the right to expect reasonable continuity of care when appropriate.

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The collaborative nature of health care requires that patients, or their families/surrogates, participate in their care. The effectiveness of care and patient satisfaction with the course of treatment depends, in part, on the patient fulfilling certain responsibilities. Patients are responsible for providing information about past illnesses, hospitalizations, medications and other matters related to health status. To participate effectively in decision making, patients must be encouraged to take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand information or instructions. Patients are also responsible for ensuring that the health care institution has a copy of their written advance directive if they have one. Patients are responsible for informing their physicians and other caregivers if they anticipate problems in the following prescribed treatment.

A person's health depends on much more than health care service. Patients are responsible for recognizing the impact of their life-style on their personal health.