ARCKC LLC

REGISTRATION FORM

Appointment date:	PCP:	Who referred you?

PATIENT INFORMATION

Patient's last name:	First:	MI:	Social Security no.:	Sex: ❑ Male ❑ Female

Street address:	Birth date:

City:	State:	ZIP Code:

Home phone no.: ( )	Work phone no.: ( )	Cell phone no.: ( )	Email:

Occupation:	Employer:	Marital status (circle one) Single / Mar / Div / Sep / Wid

If full-time student, school name:	If resident of nursing home, facility name:	Preferred language:

Race (optional): Check all that apply
- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ White/Caucasian
- ❑ Hispanic
- ❑ Hawaiian or Other Pacific Islander
- ❑ Other Race

Ethnicity (optional):
- ❑ Hispanic
- ❑ Not Hispanic or Latino
- ❑ Unknown

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Phone no.: ( )

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Stepparent ❑ Other

PRIMARY insurance name:	Policy no.:	Group no.:	Effective date:

Copay:	Deductible:	Employer group name (if applicable):

Subscriber's name:	Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Stepparent ❑ Other

Subscriber's address (if different than patient):	Subscriber's S.S. no.:	Birth date:

SECONDARY insurance name:	Policy no.:	Group no.:	Effective date:

Copay:	Deductible:	Employer group name (if applicable):

Subscriber's name:	Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Parent ❑ Stepparent ❑ Other

Subscriber's address (if different than patient):	Subscriber's S.S. no.:	Birth date:

CONTACTS

Spouse Name:	Parent(s), if patient is a minor:

Emergency contact name/address:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

ARCKC LLC
Allergy and Rheumatology Clinics of Kansas City
10460 Mastin Street, Overland Park, KS 66212
Ph (913) 338-3222 Fax (913) 338-3227

James D. Anderson, MD
Aruna Baratham, MD
Nancy Y. Olson, MD

PHARMACY INFORMATION

Our office electronically sends prescriptions to local and mail order pharmacies. Please provide us with the following information and provide as much information as you can. For mail-order pharmacies, you must provide us with the fax#. If you don't know the number, please contact them for the needed information. Thank you.

YOUR NAME:______________________ DATE OF BIRTH__________

LOCAL PHARMACY

Pharmacy name: ____________________________________

Address or Intersection:______________________________

City/State:____

Pharmacy phone:____________________________________

MAIL-ORDER PHARMACY

Pharmacy name:_____________________________________

Mail Order FAX#_____________________________________

ARCKC LLC FINANCIAL POLICY, effective 1/1/2014

Thank you for choosing ARCKC LLC as your health care provider.

The following is a statement of our **Financial Policy.**

If you HAVE HEALTH INSURANCE...

- You are responsible to supply us with correct, current insurance information.
- Please notify us of any changes in your address or telephone number.
- ALL copays are due at the time of service.
- If you have NOT met your deductible for the year, $150 prepayment toward the visit is due at time of service for new patients and $100 for follow-up patients. We will refund overpayments and bill for remaining balances after insurance pays.
- Referrals are your responsibility and must be current prior to your visit.
- You may not self pay, and then ask us to file with your insurance at a later time.
- You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance company.

If you DO NOT HAVE HEALTH INSURANCE...

- Payment in full is due at the time of service.
- We accept cash, check, VISA, Mastercard and Discover.

Our business office is available 8:30am to 4:30pm Monday, Tuesday and Wednesday to answer any questions or address any concerns you have. If you receive a statement from our office, then we expect payment from you. If you disagree with the balance for any reason, please contact our business office immediately at 913-338-3222, ext. 312.

A parent who brings a minor child to our office for medical care is responsible for payment of all of the child's charges.

A $30 fee is charged for returned checks.

A $50 no-show fee will be charged for appointments not cancelled 24 hours in advance.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependents) by ARCKC LLC. I understand and agree that if the office places my account with an agency or attorney for collection, the office shall be paid by me for all collection costs to the extent allowed by applicable law.

I HAVE READ AND AGREE TO THIS FINANCIAL POLICY:

______________________________ Date:______________
Signature of Patient or Responsible Party

____
Printed Name

****Credit/Debit Policy****

Patient Name ______________________________
ARCKC Account # (office use) ________________

I understand it is the policy of ARCKC LLC (collectively "the office") to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of U.S. law.

If, after a claim has been submitted to my insurance carrier and either: **1)** the claim is denied; OR **2)** there is a patient responsibility (i.e., deductible, co-insurance, etc.), the office will send a statement notifying me of the balance due. If this amount is not paid within 30 days, then my credit or debit card will be charged for the **entire balance** owed for treatment of services provided to me or my dependent.

I understand my insurance company provides an explanation of benefits (EOB) that notifies me how much of these charges are paid by insurance and which portion is considered patient responsibility. In the event your patient responsibility exceeds $250, the office will provide a courtesy call to my home or cell number.

I understand that in the event my credit or debit card has been charged for medical treatment of services, and then my insurance carrier subsequently makes payment to the office for those charges, the office will issue a credit to my credit or debit card or will mail a refund check.

Please Circle one of the following:
VISA / MC / Discover

Name on Card: ______________________________

Card Number: ______________________________
(card must be present when this form is turned in)
Expiration Date: ______________________________

Security Code: ______________________________

ZIP Code: ______________________________

I hereby authorize ARCKC LLC and its designated employees to charge my credit/debit card as designated above, the patient responsibility and/or denied amount for medical treatment and services provided by the office. The charge will be based on the medical treatment rendered to me (or, my dependent) and the usual and customary charges made by the office for such treatment and service. If payment is denied by my credit or debit card company, I will pay the entire amount within 30 (thirty) days.

______________________________ Date:______________
Signature of Patient or Responsible Party

____
Printed Name