

Gates E. Hoover, M.D.
Pediatric & Adult Allergy, Asthma & Immunology
www.salemallergy.com

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PCA Center for Allergy, Asthma & Immunology
Lee Hi Medical Center
2155 Apperson Drive
Salem, VA 24153

Lexington Satellite
108 Houston Street
3rd Floor, Suite F
Lexington, VA 24450

I would like to take this opportunity to welcome you to the PCA Center for Allergy, Asthma and Immunology. Thank you for giving us this opportunity to serve you. Your health is very important to us. We will work hard to give you the best allergy and asthma care possible.

In order to get the most from your visit with us, we request you follow the instructions below:

- 1) Please **do not take any antihistamines for at least 5 days prior to your visit**. A list of medications that should **not** be taken is included in this packet.
- 2) You may continue to use your asthma medications, **however please do not take the following medications on the day of your appointment only:** Albuterol, Xopenex, Advair, Serevent, Foradil and Combivent. You may resume these medications after your appointment as directed by Dr. Hoover.
- 3) Enclosed is a questionnaire. Please read it carefully and **complete the questionnaire prior to your visit**. This will help to make your time here as productive as possible.
- 4) If a referral from your primary care doctor is required, please obtain the referral prior to your visit. Otherwise, we will not be able to see you.
- 5) Please **arrive 15 minutes prior to your appointment** to be registered. Remember to bring along your insurance card and ID (driver's license).
- 6) **Co-pays will be collected at the time of your visit**. We accept cash, check and credit cards.
- 7) New patient visits usually take 2 – 3 hours. Please plan accordingly. We encourage you to bring reading materials, along with toys and snacks for your children.
- 8) Women and girls, if possible, should wear a separate top and bottoms and bring hair clips to allow for testing.
- 9) Patient appointments are in high demand. **If you cannot keep your appointment, please notify us as soon as possible (at least 24 hours in advance). Otherwise, you will be charged a no show fee.**

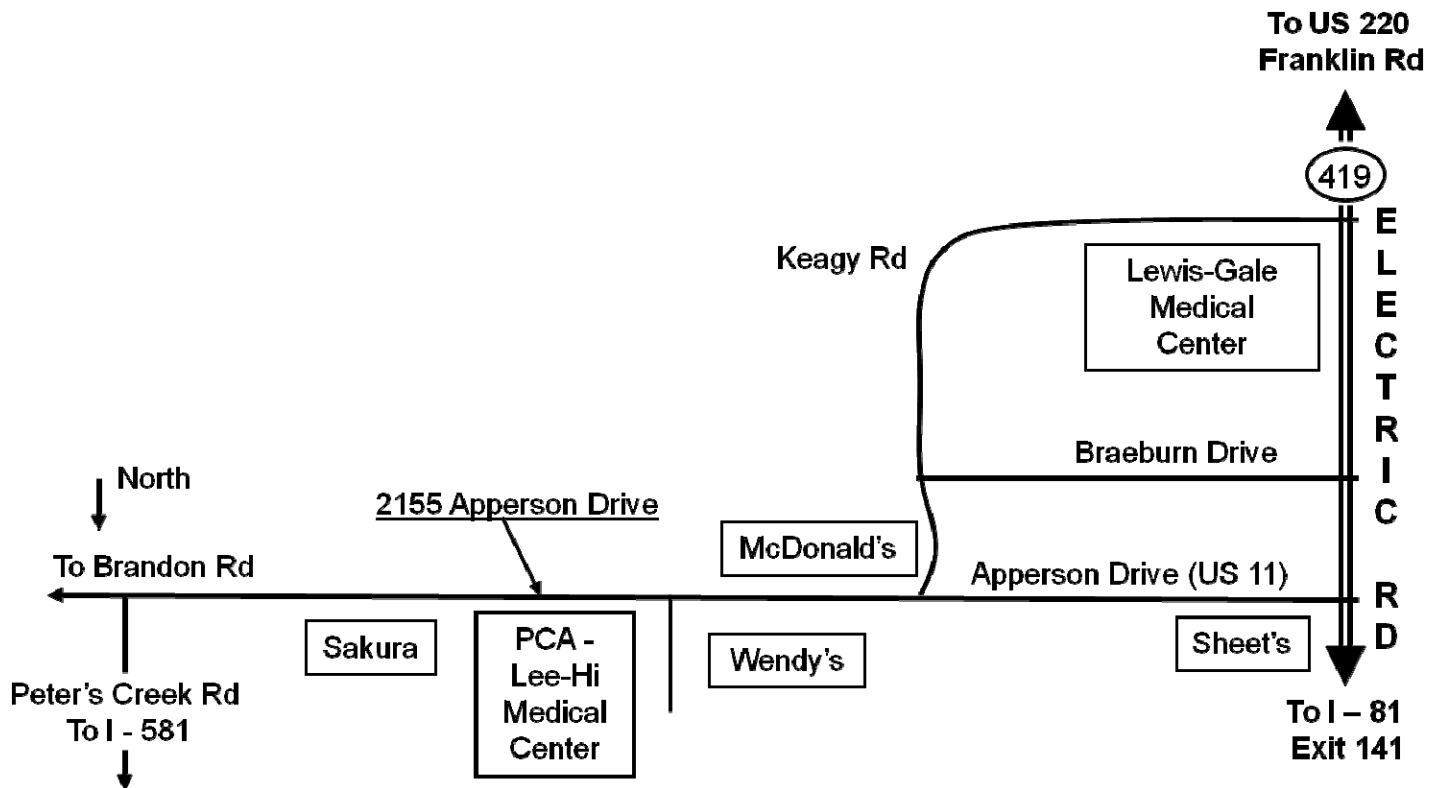
If there are any questions prior to your visit, please call us at the above number. Thank you for choosing our office for your allergy and asthma care.

Sincerely,

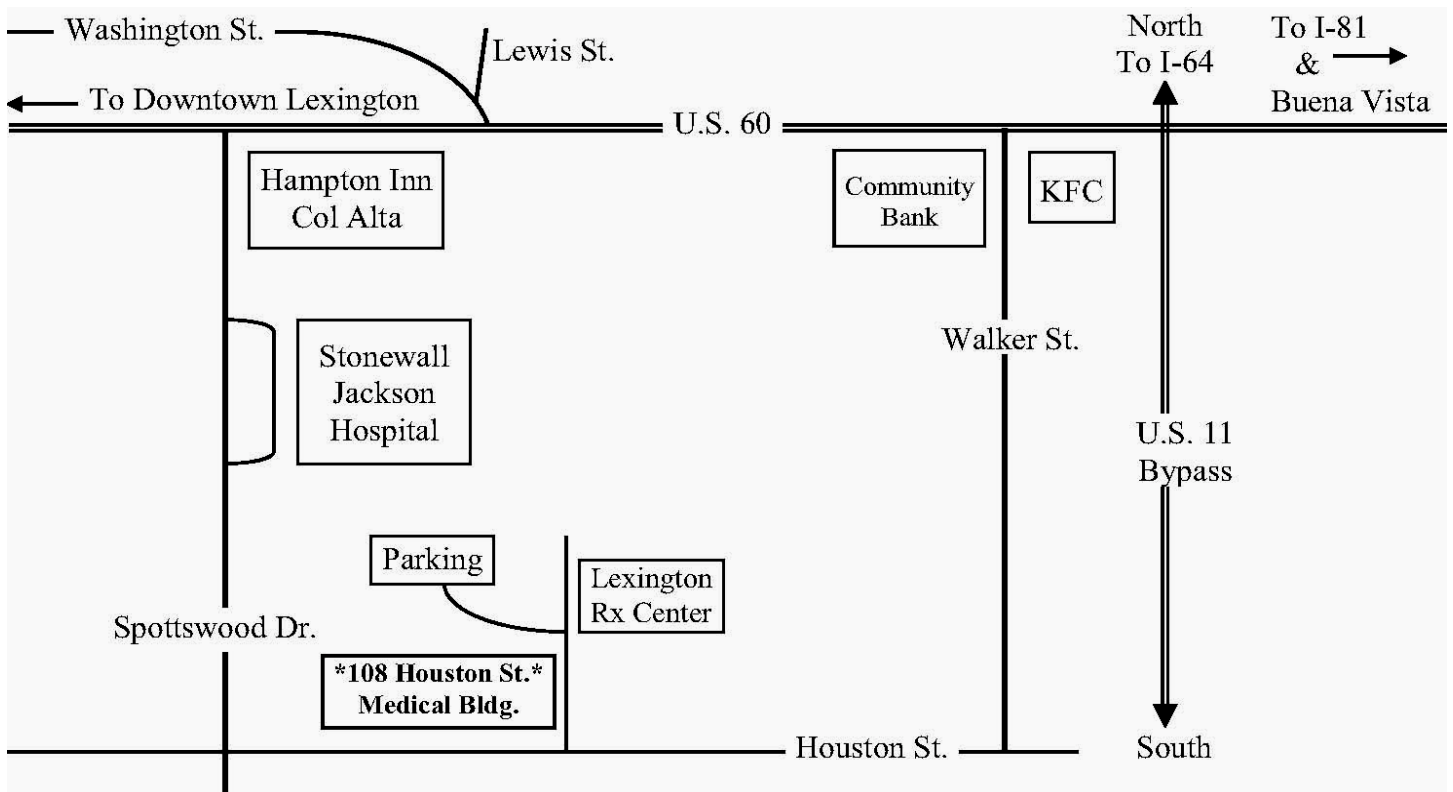
Gates E. Hoover, M.D.
Diplomate, American Board of Allergy and Immunology

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Directions to the Salem (Lee-Hi) Office at 2155 Apperson Drive, Salem, VA 24153



Directions to the Lexington Office at 108 Houston St, 3rd Floor Ste. , Lexington, VA 24450



Gates E. Hoover, M.D.
PCA Center for Pediatric & Adult Allergy, Asthma & Immunology
Lee Hi Medical Center
2155 Apperson Drive, Salem, VA 24153

Phone: (540) 776-5656

FAX: (540) 772-6805

PLEASE AVOID THE FOLLOWING MEDICATIONS FOR AT LEAST 5 DAYS PRIOR TO YOUR APPOINTMENT:

Acrivastine (Semprex-D)

Azatadine (Optimine)

Azelastine (**Astelin**)

Brompheniramine

(**Bromphed** & other OTC cough & cold medications)

Carbinoxamine

Cetirizine (**Zyrtec**)

Chlorpheniramine

(eg. Chlor-Trimeton, Effidac-24, and other OTC cough & cold medications)

Chlorpromazine (Thorazine)

Clemastine

(eg. Allerhist, Tavist, Contact 12 hr Allergy)

Cyclobenzaprine (**Flexeril**)

Cyproheptadine (Periactin)

Desloratadine (**Clarinex**)

Diphenhydramine

(eg. **Benadryl**, Caladryl, Tylenol PM, Sominex and other over-the-counter cough & cold and sleeping pills)

Doxylamine (**NyQuil**)

Feverfew

Fexofenadine (**Allegra**)

Green Tea

Haloperidol (Haldol)

Hydroxyzine (**Atarax**, Visteril)

Ketotifen (**Zaditor** eye drops)

Loratadine (**Claritin**, Alevert & Equate Brand)

Licorice

Meclizine (**Antivert**)

Methocarbamol (**Robaxin**)

Orphenadrine (**Norflex**)

Promethazine (**Phenergan**)

Prochlorperazine (**Compazine**)

Pyrilamine (Statuss)

Saw Palmetto

St. John's Wort

Triplennamine (PBZ)

Patanase (Olopatadine)

Xyzal (Levocetirizine)

PLEASE AVOID THE FOLLOWING MEDICATIONS FOR AT LEAST 7 DAYS PRIOR TO YOUR APPOINTMENT: (CAUTION: DISCUSS WITH THE PRESCRIBING DOCTOR BEFORE STOPPING ANY OF THESE MEDICATIONS)

Aripiprazole (**Abilify**)

Amitriptyline (Elavil)

Amoxapine

Clomipramine (Anafranil)

Clozapine (Clozaril)

Desipramine (Norpramin)

Doxepine (Sinequan)

Effexor (Venlafaxine)

Imipramine (Tofranil)

Loxapine (Loxitane)

Maprotiline

Mirtazapine (**Remeron**)

Nortriptyline (Pamelor)

Quetiapine (**Seroquel**)

Thioridazine

Thiothixene

Trifluoperazine

Trimipramine (Surmontil)

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PCA Center for Pediatric & Adult Allergy, Asthma & Immunology

QUESTIONNAIRE

Name _____ DOB _____ Sex _____ Date _____

Referring or Primary Care Physician _____

Please list your **3 main symptoms** or problems. Be specific, **please do not just write "allergies"**. Then complete rest of questionnaire.

- 1) _____
 2) _____
 3) _____

From the lists please check other symptoms that are problematic. **For Chest and other problems: see pages 2 - 3.**

NASAL & SINUS:

- congestion / stuffiness itching
 sneezing crusting
 nosebleeds mouth breathing
 loss of taste or smell snoring (if so any apnea: Y / N)
 runny (color _____)
 pain / pressure (describe on page 2)
 infections (# / yr _____; respond to antibiotics? Y / N)
 polyps (if removed, when _____)
 deviated septum (if repaired, when: _____)

THROAT:

- itching / tickling clearing of throat
 hoarseness sore throats
 swollen glands difficulty swallowing
 tightness / fullness
 post-nasal drainage (color _____)
 itching / swelling: tongue, throat or roof of mouth
 tonsillitis: # / yr _____; respond to antibiotics? Y / N
 tonsillectomy / adenoidectomy (date: _____)

Previous Sinus X-ray or CAT scan (date(s) & results: _____

Sinus surgery (include date(s) & response): _____

EYES:

- redness tearing
 shiners/ puffiness swelling: lids conjunctiva
 itching / burning: lids eyes both
 discharge / drainage (color _____)

EARS:

- fullness / popping itching
 hearing loss dizziness / light headedness
 ringing in ears pain (left / right / both)
 infection: # / yr _____; respond to antibiotics? Y / N
 tube placement (date(s): _____)

How long have the above symptoms been present: _____ Impact on quality of life: mild moderate severe debilitating

How often do these symptoms occur: _____ Lately, have the symptoms: worsened improved not changed

Symptoms are: year round seasonal (circle which months): Jan / Feb / Mar / Apr / May / Jun / Jul / Aug / Sept / Oct / Nov / Dec

Symptoms occur mainly: indoors outdoors both morning afternoon evening night no difference

Aggravating Factors (For above symptoms only, see below for chest, skin & abdominal symptoms):

- | | |
|---|---|
| <input type="checkbox"/> making or laying on the bed | <input type="checkbox"/> weather: <input type="checkbox"/> hot <input type="checkbox"/> humid <input type="checkbox"/> cold <input type="checkbox"/> windy <input type="checkbox"/> changes |
| <input type="checkbox"/> sweeping / vacuuming indoors | <input type="checkbox"/> air conditioning: <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> no difference |
| <input type="checkbox"/> animals: <input type="checkbox"/> cats <input type="checkbox"/> dogs <input type="checkbox"/> other: _____ | <input type="checkbox"/> eating / drinking (what foods: _____) |
| <input type="checkbox"/> mowing the grass | <input type="checkbox"/> vacation or moves: <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> no change |
| <input type="checkbox"/> raking leaves / gardening | <input type="checkbox"/> work: <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> no difference |
| <input type="checkbox"/> pollens: <input type="checkbox"/> trees <input type="checkbox"/> weeds <input type="checkbox"/> grasses | other: _____ |
| <input type="checkbox"/> hiking / camping | _____ |
| <input type="checkbox"/> strong odors / fumes / smoke | _____ |

Previous therapy (list past treatments & note type of response):

	IMPROVEMENT?	Yes	No
Antibiotics: _____		_____	_____
Antihistamine &/or decongestants: _____		_____	_____
Nasal sprays: _____		_____	_____
Systemic steroids: _____ Date(s) of use _____		_____	_____
Allergen injections: Dr: _____ Date(s) _____		_____	_____
Dr: _____ Date(s) _____		_____	_____
Positive skin tests (please include date(s): _____			

HEADACHES:

Location: _____ Travels to: _____ Severity (from 1 to 10): _____
How Frequent _____ Usual Duration _____ Onset: ___gradual vs. ___sudden
Quality: ___sharp ___stabbing ___band-like ___boring ___throbbing ___pressing ___dull
Associated Symptoms: ___nausea ___blurring / changes of vision ___light sensitivity ___numbness / tingling of _____
Aggravated by: _____
Relieved by: _____
Previous Treatment (Helped Y / N): _____

CHEST:

___shortness of breath ___cough: ___dry ___hacky ___croupy ___paroxysmal
___chest tightness ___sputum: ___only with acute infections ___chronic (am't per day: _____ duration: _____ mos / yrs)
___difficulty breathing color _____ any blood? Y / N; when _____
___stridor ___wheezing: ___during inspiration ___during expiration

How long have the above symptoms been present: _____ How often do these chest symptoms occur (on average): _____
How do the symptoms develop: ___suddenly ___gradually How long does each episode last (on average): _____
Lately, the symptoms have: ___worsened ___improved ___not changed
Do these symptoms wake you (or your child) at night: Y / N If yes, how many times per month (on average): _____
Do any of the following relieve the nocturnal symptoms: ___cool air ___vaporizer ___sitting upright ___inhaler
Do "colds" often lead to bouts of "bronchitis" or "wheezing": Y / N If yes, how many times per year _____
Episodes of pneumonia: Y / N If yes, list date(s) & note chest x-ray result _____
Number of missed school or work days over last year: _____ Number of ER visits & date of last visit _____ / _____
Number & dates of hospitalizations _____ / _____ Impact on quality of life: ___mild ___moderate ___severe ___debilitating
Symptoms are: ___year round ___seasonal (circle which months): Jan / Feb / Mar / Apr / May / Jun / Jul / Aug / Sept / Oct / Nov / Dec
Symptoms occur mainly: ___indoors ___outdoors ___both ___morning ___afternoon ___evening ___night ___no difference

Aggravating Factors (For chest symptoms only, see below for skin & abdominal symptoms):

___ making the bed ___ gardening
___ sweeping / vacuuming indoors ___ hiking / camping
___ cats / dogs / other pets: _____ ___ strong odors / fumes
___ mowing the grass ___ weather: hot / humid / cold / windy / changes
___ raking leaves ___ infections
___ pollens: ___trees ___weeds ___grasses ___ strong emotions / laughter
___ exercise: ___during ___after ___ eating (what foods: _____)
type of exertion: _____ other: _____
am't or distance of exertion: _____

Previous Evaluation:

Pulmonary Function Tests (if yes, please give date(s) & results: FVC, FEV1, Diffusion Capacity): _____
Chest X-rays &/or CAT scans (if yes, please give date(s) & results): _____
Sweat Chloride Test, Alpha-1-Antitrypsin Level or Immunoglobulin Levels (if yes, gives date(s) & results): _____
TB Test (PPD) if positive please give date, chest x-ray result & type of treatment required: _____

Previous therapy (list past treatments for your chest symptoms & note type of response):	IMPROVEMENT?	Yes	No
Antibiotics: _____	_____	_____	_____
Bronchodilators (i.e. Albuterol): _____	_____	_____	_____
Inhaled Steroids (please note the amount of time on each) : _____	_____	_____	_____
Systemic steroids: _____ Date(s) of use _____	_____	_____	_____
Singulair, Theophylline or Others: _____	_____	_____	_____

INSECT STINGS (Please describe the reaction for insect stings only):

___large localized redness & swelling ___throat / chest tightness ___shortness of breath ___light headedness
___generalized hives / redness / itching ___wheezing ___stridor ___loss of consciousness
blood pressure: ___decreased ___increased heart rate: ___increased ___decreased
Date the reaction occurred: _____ how soon after the sting did the reaction start & how long did it last: _____ / _____
What insect(s) cause the reaction: honey / sweat bee wasp yellow jacket white / yellow faced hornet other: _____
What treatment was required: _____

SKIN:

___dry & itchy (eczema) ___"swelling" (angioedema) ___red & itchy with blistering ___thick scaly plaques
___"flushing" ___hives: ___large blotchy ___small pin point a single hive lasts how long _____)
Date of onset: _____ How long will a single area of rash or hive last: _____
Location on body: _____
Other associated symptoms _____

Aggravating factors:

___heat ___cold ___pressure ___sun exposure ___scratching ___dust ___pollens ___animal danders ___latex
foods: _____ medications: _____
contact allergens: ___poison ivy / oak ___neosporin ___rubber ___nickel ___soaps ___shampoo ___hair dye ___detergent
___cosmetics ___creams / lotions / moisturizers ___topical medications: _____
Recent treatments: _____

GASTROINTESTINAL:

___nausea ___vomiting ___diarrhea ___heartburn ___acidic splash ___bloating ___gas
___constipation ___bloody stools ___black tarry stools ___weight loss (unintentional), how much: _____
___abdominal pain: ___sharp ___achy starts at: _____ travels to: _____
associated with what foods _____
associated symptoms _____
How soon after eating _____ how long do symptoms last _____

REVIEW OF SYSTEMS:

GENERAL: ___fevers ___fatigue ___night sweats ___swollen glands other _____
HEAD: ___previous injury other _____
EYES: ___cataracts (or prior cataract surgery) ___glaucoma other _____
EARS: other than above _____
NOSE: other than above _____
ORAL / NECK: ___delayed or abnormal speech ___cleft palate other _____
CHEST: ___chest pain: location: _____ travels to: _____
occurs: ___at: rest ___with exertion ___with deep breathes other: _____
type: ___sharp ___dull ___pressure other _____
how often: _____ lasts how long: _____
aggravated by _____ relieved by: _____
other associated symptoms: _____
___deformity other _____

CARDIOVASCULAR: ___heart murmur ___irregular heart ___palpitations ___stroke ___heart attack ___high blood pressure

ABDOMEN: ___jaundice ___peptic ulcer other _____

EXTREMITIES: ___deformity ___swelling of the feet ___joint swelling / pain / tenderness (which joints: _____)

SKIN: ___athlete's foot or toe nail fungus ___warts other _____

ENDOCRINE: ___heat or ___cold intolerance ___excess thirst ___high blood sugar other _____

HEM / ONC: ___anemia (low blood count) ___easy bruising / bleeding other _____

URINARY: ___frequent urination ___burning ___blood in urine frequent infections: ___yeast ___bladder ___kidney
___kidney stones ___difficulty urinating other _____

NEUROLOGIC: ___recent change of vision ___numbness / tingling / weakness (where _____)
other: _____

PAST MEDICAL HISTORY (Please list all medical problems that have required medical treatment or surgery & the date of occurrence)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Have you (or your child) ever had chicken pox or the vaccine for chicken pox? Y / N

Children ONLY: Gestational Age: full term / other: _____ WGA Birth weight: _____ Delivery: _____

Any problems with pregnancy or delivery (if yes, describe) _____

Was oxygen or a ventilator required (if yes, how long: _____) Did the mother smoke during the pregnancy: Y / N

Childhood Immunizations: Up To Date? Y / N If no, what is lacking _____

DRUG ALLERGY OR REACTIONS: ***Please list name of drug, date of the reaction, reason for drug, type of symptoms, duration of treatment before symptoms started, how soon after dose did the symptoms start and how long did the symptoms last.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| _____ | _____ |
| 2. _____ | 5. _____ |
| _____ | _____ |
| 3. _____ | 6. _____ |
| _____ | _____ |

CURRENT MEDICATIONS: *** Please list ALL the medications taken in the past 2 weeks (including over the counter medications, nasal sprays, inhalers, medicated lotions / creams, vitamins & health supplements).

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

FAMILY HISTORY (Please check):	Mother	Father	Brothers	Sisters	Aunts	Uncles	Children
Nasal allergy / chronic sinusitis:	_____	_____	_____	_____	_____	_____	_____
Asthma:	_____	_____	_____	_____	_____	_____	_____
Eczema / atopic dermatitis:	_____	_____	_____	_____	_____	_____	_____
Chronic hives / angioedema:	_____	_____	_____	_____	_____	_____	_____
Food allergy:	_____	_____	_____	_____	_____	_____	_____
Medication allergy:	_____	_____	_____	_____	_____	_____	_____
Emphysema:	_____	_____	_____	_____	_____	_____	_____
Other chronic lung / liver diseases:	_____	_____	_____	_____	_____	_____	_____
High blood pressure:	_____	_____	_____	_____	_____	_____	_____
Diabetes:	_____	_____	_____	_____	_____	_____	_____
Heart disease / stroke:	_____	_____	_____	_____	_____	_____	_____
Migraines:	_____	_____	_____	_____	_____	_____	_____
Cancer:	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____

SOCIAL / ENVIRONMENTAL HISTORY:

In which city / county do you (your child) live? _____ The area is: ___urban ___suburban ___rural
 In a(n): ___rented ___owned The lower level is: ___damp ___dry ___has had water damage
 ___house (how many levels? _____) ___at ground level on a concrete slab
 ___apartment / condo (what level: _____) ___over a crawl space: ___dry ___damp
 ___mobile home ___a basement:: ___unfinished: ___dirt ___cinderblock ___concrete
 How old is the building? _____ years old ___finished: ___tile ___linoleum ___carpet
 How long have you lived at this location? _____
 Where have lived previously? _____

SOCIAL / ENVIRONMENTAL HISTORY (continued) regarding your current living accommodations:

HEATING

___ central heat
___ radiator
___ base board / coil heat
___ fireplace: gas / wood
___ wood stove

COOLING

___ central a/c
___ window a/c
___ water pipes
___ fans: window / box / attic
___ humidifier

ANIMALS (number of each)

___ cats: ___ indoors ___ outdoors ___ bedroom
___ dogs: ___ indoors ___ outdoors ___ bedroom
___ hamsters / gerbils / guinea pig / rabbit / ferret: ___ indoors ___ bedroom
___ birds (type: _____) ___ indoors ___ bedroom
___ horses / cattle / other: _____

Any indoor pests? ___ cockroaches ___ ladybugs ___ rats / mice other: _____

Any indoor plants: few / several / many (in bedroom? Y / N) Any indoor mold growth? Y / N (where _____)

BEDROOM (the patient's): what level? _____ carpeted ___ non-carpeted ___ area rugs how many beds? _____

Bed mattress:

___ cotton-filled
___ water
(cover: ___ vinyl ___ cotton-filled)

Pillows:

___ synthetic ___ foam
___ feather ___ other

Collections:

___ stuffed animals ___ upholstered furniture ___ cards
___ toys / games ___ books / book case ___ TV / VCR
___ CD's ___ trophies ___ clothes

Other indoor collections: _____

Have you ever smoked? Y / N, if yes: how many packs/day: _____ how long have you smoked: _____ quit date: _____

Does anyone else living at home smoke? Y / N ; if yes, how many? _____. Does your child attend group child-care? Y / N

Do you drink any beer, wine or other alcoholic beverages? Y / N ; if yes, how much: _____ per day / week / month

Have drank heavily in the past? Y / N Have you used recreational drugs? Y / N ; if yes, list: _____

If you (or your child) have a second residence, please describe: _____

What is your current occupation (if child, give grade in school)? _____

What are you (or your child) exposed to a work / school? _____

List previous occupations & exposures? _____

List hobbies, activities or extracurricular activities: _____

Other: _____

Doctor's Notes (Please do NOT write in the area below. Thank you!):

Reviewed by: _____ M.D. Date: _____

Gates E. Hoover, M.D.

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PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Last Name: _____ First Name: _____ Middle Name: _____
Date of Birth: _____ Soc Sec #: _____ Sex: _____ Marital Status: _____
Address: _____ City/State: _____ Zip Code: _____

HOME PHONE: _____ **CELL PHONE:** _____

Employer Name: _____ Phone: _____
Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____
Home Phone #: _____ Work #: _____
Address: _____ City/State: _____ Zip Code: _____

INSURANCE INFORMATION

Name of **Primary Insurance Company:** _____

Primary Care Physician: _____ **phone#:** _____

Subscriber Last Name: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: _____ **Soc Sec #:** _____ **Sex:** _____ **Relationship to Patient:** _____

Policy #: _____ **Group #:** _____

Employer Name: _____ **Phone #:** _____

Address: _____ **City/State:** _____ **Zip Code:** _____

Secondary Insurance: _____ **YES (If yes, please complete additional insurance form)** _____ **NO**

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments deemed necessary. The administration of any needed anesthetics and the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient. The use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

MEDICARE PATIENTS: I authorize Primary Care Associates, P.C. to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Primary Care Associates, P.C..

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia, (whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Center of Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed and the Virginia Health Department and appropriate counseling will be offered.

I have reviewed and understand my PATIENT RIGHTS AND RESPONSIBILITIES. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature (or responsible party) _____ Date: _____

I acknowledge that I have received a copy of Primary Care Associates' Notice of Privacy Practices, dated 3/1/03.

Signature of patient or Patient's Representative _____ Date _____

Printed Name of Patient's Representative _____ Relationship to Patient _____

Evidence of the authority of the patient's representative (please attach to this acknowledgement)

ADDITIONAL INSURANCE

Name of Secondary Insurance Company: _____

Primary Care Physician: _____ Phone #: _____

Subscriber Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Soc Sec #: _____ Sex: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Employer Name: _____ Phone #: _____

Address: _____ City/State: _____ Zip Code: _____

Name of Tertiary Insurance Company: _____

Primary Care Physician: _____ Phone #: _____

Subscriber Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Soc Sec #: _____ Sex: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Employer Name: _____ Phone #: _____

Address: _____ City/State: _____ Zip Code: _____

Patient Signature (or responsible party) _____ **Date** _____



Financial Agreement

I authorize the payment of all insurance benefits to PCA. I agree that I am responsible for all co-pays, non-covered services and balances not covered by my insurance. I understand 18% interest may be charged on all past due accounts I owe. I agree that I may incur 5% late fees on past due balances I owe. I authorize the release of pertinent medical information to third parties and/or insurance carriers to obtain payment for services rendered. I understand that if I do not have proof of insurance or the necessary authorization that I am responsible for all charges. If I have a delinquent account that is turned over for collection, I agree to pay attorney fees equal to 25% of the principal balance owed in addition to the account balance, late fees and interest due. This agreement shall be legally binding to all services rendered and to any previously unpaid services of PCA.

Patient name (Printed)

Signature

Date

Revision date 5/8/2009

Patient Account # _____

Copy sent to Collections Department on _____ by _____
(Date sent) (Front office employee name)