

Allergy Care Centers



Care for All Seasons

Request for treatment... Authorization for assignment of benefits and information release.

Participating Insurance

I hereby request Allergy Care Centers to provide whatever treatment it may deem necessary to the named patient below. I hereby request payment of authorized benefits and/or any insurance benefits to be paid directly to Allergy Care Centers for any services furnished to the patient by any physician on staff. I authorize Allergy Care centers and staff to release to my insurance carrier and its agents any information concerning health care advice, treatment provided to the patient needed to determine these benefits or the benefits payable for related services. I understand I am responsible for charges not covered by the insurance policy (excluding workman's compensation cases), and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all costs.

Signature: _____ **Date:** _____
Signature of Patient/Responsible party if minor

Private Pay

I hereby request Allergy Care Centers to provide whatever treatment they may deem necessary to the patient above. I understand that I am responsible for charges incurred for services and that payment is due at the time of service. It is my responsibility to bill my insurance company for these fees unless other arrangements are made. I understand I am responsible for charges and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all costs. I authorize Allergy Care Centers and staff to release to my insurance carrier and its agents any information concerning health care, advice, treatment provided to the patient, needed to determine these benefits or the benefits for related services. Signature of Patient/Responsible party if Minor Date

Signature: _____ **Date:** _____
Signature of Patient/Responsible party if minor

Patients with Medicare Lifetime Assignment of Benefits

Name of Beneficiary: _____ **Medicare #:** _____

Name of Beneficiary Medicare Number I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Allergy Care Centers for any services furnished me by either of the physicians on staff. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to Allergy Care Centers and its staff, any information regarding my Medicare claims under Title XVIII of the Social Security Act.

Signature: _____ **Date:** _____
Signature of Patient/Responsible party if minor

I, undersigned patient of Allergy Care Centers, do hereby permit a copy of these authorizations and assignments to be used in place of this original which is on file at the Allergy Care Centers.

Lifetime Release of Information:

I authorize any physician examining and/or treating me to release to any third party (such as insurance company or governmental agency) any medical information and records concerning diagnosis and treatment when requested for use in determining claim or payment.

Signature: _____ **Date:** _____
Signature of Patient/Responsible party if minor