## Family Allergy and Asthma Associates General Release Form

**Patient Name:** ___________________________ **Date:**____________________________

**Responsible Party:** _______________________**Date:**____________________________

**<u>TO SUBMIT CLAIMS TO INSURANCE:</u>** I hereby authorize Family Allergy and Asthma Assoc. to apply for benefits on my behalf for covered services rendered by the practice, and request that the payments are made directly to Family Allergy and Asthma Assoc. I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. I will be responsible for payment of any services rendered, even if I was no longer covered by my stated insurance carrier at the time such services were rendered, if the necessary referral(s) were not obtained and/or submitted to Family Allergy and Asthma Assoc. prior to my receiving services here, or if for any reason my insurance carrier deems this is a non-covered benefit. **All copays and outstanding balances are due at the time of service.** In addition to the above information, I understand that my insurance is a contract between my insurer and myself, not with the doctor's office. It is also my responsibility to contact my insurance to determine coverage, regardless of any estimate of coverage given by the doctor's office. **We do not bill any secondary insurances.**

SIGNATURE_________________________________________DATE______________________

**NON-PAYMENT:** I understand that the submission of an insurance claim is not a guarantee of payment. I further understand that if my account is turned over to a collection attorney/collection agency for nonpayment, I will be responsible for any/ all of the attorney's/collection agency fees of and interest at 18% per annum from the date services were rendered. I understand that if my personal check is returned, I will be charged a fee of $30.00 for re-depositing and/or replacement of returned check. All cancellation or changes in appointments must be made at least 24 business hours prior to the appointment to avoid a $35.00 fee for clinic visits and a $10.00 fee for allergy injections.

SIGNATURE_________________________________________DATE______________________

**MEDICAL RECORDS RELEASE:** I hereby authorize Family Allergy and Asthma Associates to release my medical records to, and to discuss my care with, my treating physicians and all other Health Care Providers. I further authorize all of my treating physicians and other Health Care Providers to release my medical records to Family Allergy and Asthma Associates.

SIGNATURE_________________________________________DATE______________________

**PRIVATE PRACTICES ACKNOWLEDGEMENT:** I hereby acknowledge that I have been provided an opportunity to review Family Allergy and Asthma Associates' Notice of Privacy practices, and I am aware that a copy will be furnished to me upon my request.

SIGNATURE_________________________________________DATE______________________