ALLERGY & ATHMA INC.

Consent to the use and disclosure of health information for the treatment, payment and health care operations.

I understand that it is important for the health care system and my doctor to maintain health records about me. These records serve as:

- As a basis for planning my care.
- A way for health care professionals to communicate about my care.
- A source of information for billing purposes.
- A means by which a third-party payer can verify that services billed were provided.
- A tool for health care operations; such as evaluating the quality of care and reviewing the competence of health care professionals.

This office's *Notice of Privacy Practice* provides information about how my health information may be used and disclosed. I have the right to review the *Notice* before signing this consent. The terms of the *Notice* may change. If the *Notice* is changed, I may obtain a revised copy by contacting the office.

I have the right to request restrictions on how health information about me is used or disclosed for treatment, payment or health care operations. I understand that Allergy & Asthma, Inc. or my doctor(s) are not required to agree to any restrictions. If they do agree, Allergy & Asthma, Inc. or my doctor(s) are bound by our agreement.

By signing this consent, I acknowledge and agree that Allergy & Asthma, Inc. or my doctors(s) may use and disclose my personal health information for the purposes of carrying out treatment, payment and health care operations for me or on my behalf. I have the right to revoke this consent in writing at any time. I understand that this revocation will not apply to any information already used or disclosed on the basis of prior written consent.

Print Name _____ **Signature** _____ **date**

Insurance Assignment and Release

I, the undersigned, have insurance coverage and I assign directly to any physician at Allergy & Asthma, Inc. at or on my behalf all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature _____ **date**

Medicare authorization / Medicare HMO Policy

I request that payment of authorized Medicare benefits be made to Allergy & Asthma, Inc. on my behalf for any services furnished by the physician(s). I authorize any holder of medical information about me to release to the Heath Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other ins" is indicated in item 9a of the HCFA-1500 form, or elsewhere on the approved claim or electronically submitted claims, my signature authorizes releasing of the information. To the insurer or agency shown, in Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the pt. is responsible for only the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

Signature _____ **date**

Witness _____ **date**