Minnesota
Allergy & Asthma
Clinic, PA

How Did You Hear of Us?

_____Yellow Pages _____ Friend _____ Relative

_____ Newspaper Ad _____ Referring/ Primary Physician _____

_____ Insurance Book _____ Website: _____

_____ Other:_____

Consent for Treatment Authorization

_____(Initials) I voluntarily consent to evaluation, diagnostic testing, medication, nursing care and/or therapy, which my physician or his/her designees, determines to be necessary. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of examination or treatment with Minnesota Allergy & Asthma Clinic, PA.

Authorization to Release Medical Information

_____ (Initials) I hereby authorize Minnesota Allergy & Asthma Clinic, PA, its employees or agents to release medical information regarding myself and my current condition to my insurance company for purposes of payment and/or quality reviews; and to referring consulting, or treating physicians. This authorization will remain valid until revoked in writing.

Authorization Medicare Patients

_____ (Initials) I request payment of authorized Medicare benefits on my behalf to Minnesota Allergy & Asthma Clinic, PA for any services furnished to me by its physicians and/or ancillary personnel. I authorize Minnesota Allergy & Asthma Clinic, PA to release to the Center for Medicare and Medicaid Services (CMS) its agents any information needed to determine these benefits or benefits payable for related services.

Assignment of Benefits

_____ (Initials) I acknowledge my payor information is correct and authorize Minnesota Allergy & Asthma Clinic, PA to directly bill my insurance. I also authorize that any payment under any insurance policy or health benefits plan to be made directly to Minnesota Allergy & Asthma Clinic, PA for any services rendered to me by or on behalf of Minnesota Allergy & Asthma Clinic, PA. If I am unable to provide complete information, I will be responsible for all charges on the account. I also understand regardless of my insurance company's assurance of coverage for any and all specific procedures as ordered by my physician, payment of any denied claim is my responsibility.

Signature of Patient or Responsible Party_____

Relationship _____ Date _____

Patient Date of Birth _____