Allergy and Asthma Center
Anita N. Wasan, MD, FAAP, FACAAI

Assignment and Release

I, the undersigned, have insurance coverage with _____ (name of insurance company) and assign benefits, if any, directly to the Allergy and Asthma Center, otherwise payable to the insured for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. The Allergy and Asthma Center will submit any claim to the appropriate insurance company. However, if the practice is considered "out of network", then the patient is responsible for all charges. If any amount due remains unpaid after a bill is rendered, I (the patient or the legal guardian of the patient) *agree* to pay all costs of collection, including reasonable attorney fees for both the practice and the patient. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

Release of Medical Records to our Practice from other Health Care Providers

I, the undersigned, authorize the Allergy and Asthma Center, to obtain any medical records that may pertain to my medical care. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released and thereby release the Allergy and Asthma Center, and staff, from all legal responsibility that may arise from the authorized.

_____ _____

Signature of Insured/Guardian Date

Notice of Privacy Practices

I have received a copy of the Allergy and Asthma Center's Notice of Privacy Practice. I understand what is said in the notice.

_____ _____

Signature of Insured/Guardian Date

Consent for Purposes of Treatment, Payment and Healthcare Operation (Reproduced from AMA/ACP model)I consent to the use or disclosure of my protected health information by the Allergy and Asthma Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Allergy and Asthma Center. I have the right to revoke this consent, in writing, at any time, except to the extent that Anita N. Wasan, MD or the Allergy and Asthma Center taken action, relying on this consent. "Protected health information" is the health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information involves my past, present or future physical or mental health or condition and identifies me (or on a reasonable basis, identifies me).

_____ _____

Signature of Insured/Guardian Date