PAYMENT AUTHORIZATION/FINANCIAL AGREEMENT

This form is a release of information, benefit assignment, payment authorization, full disclosure statement, and agreement to pay for professional services.

I _____, authorize Asthma & Allergy Center to release any information acquired during the course of my examination or treatment to my insurance company and Davidson Consulting Inc. for the purposes of processing my insurance /medical claim. I agree to allow a photocopy of my signature to be used to process myinsurance/medical claim for the period of Lifetime. I claim any insurance benefits due me for services rendered by Asthma & Allergy Center and authorize and assign payment directly to Asthma & Allergy Center, regardless of my insurance benefits.

It is the policy of this practice that a divorced parent who seeks care fore their minor child becomes the responsible party. Thus, Asthma & Allergy Center shall not negotiate billing issues of separated or divorced parents regardless of your custody agreement. The parent that brings the child to the initial visit is responsible for payment at the time of service.

I have fully disclosed all information concerning the insurance/third-party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur liability for professional charges as a result of non-payment by any carrier.

Patient Name: _____

Patient/Guardian Signature: _____

Relationship to Patient: _____

Date: _____