

Advancements in Allergy and Asthma Care, Ltd.
Consent, Payment Authorization Form and Notices of Privacy Practices

Please read, provide your initials next to each category and sign the document below. By signing, you acknowledge that you have read, understand and agree with the Consent, Payment Authorization, and Notice of Privacy Practices Form and the conditions stated within.

«PatientFullName»
DOB: «PatientDOB»

Consent for Treatment

I authorize Advancements in Allergy and Asthma Care, Ltd. (“AAAC”) to provide any treatment, including the performance of the diagnostic tests, procedures, and/or the administration of the medications which may be deemed appropriate by the physician, provider or other personnel involved in my care. I understand and consent that persons receiving medical training may be involved in my care.

Consent and Authorization for Release of Information

I consent to the release and use by AAAC of medical and other information about me to the extent permitted by law to a health care provider being advised or consulted in connection with my treatment or care; a health plan, insurer, third-party payer, third-party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies; and to a person or organization in connection with AAAC’s health care operations (e.g. interdisciplinary healthcare conferences, quality improvement activities, performance evaluations, business management, and other related activities). I consent that AAAC may leave detailed voice messages for me on any phone number that I provide to AAAC. I expressly acknowledge and consent that such voice messages may contain protected health information about my treatment, care, medical conditions, and test results.

I consent to the release of medical and other information about me to the following other individuals (e.g. spouse, family member, coach, trainer, employer, etc): _____

I understand this consent will continue until revoked, which can be done at any time by providing written notice to AAAC.

Respectful Conduct and Feedback

I agree to act in a respectful manner in all of my interactions with AAAC staff, including any feedback I provide. I agree to communicate any concerns with AAAC to AAAC’s office manager and provide AAAC a reasonable opportunity to address my concerns before making any public statements. If I provide feedback related to my experience with AAAC or its staff, I agree and hereby do assign ownership of all feedback to AAAC. This assignment includes the copyrights to all feedback, whether oral or written, and regardless of where and how I provide the feedback.

Payment Authorization

Payment Responsibility. I agree to pay for all services furnished to me by AAAC, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third party payers, upon receipt of statement, except as prohibited by AAAC’s contract with my health plan or applicable law. I also agree to pay or reimburse AAAC for all costs it may incur in collecting such amounts, including, but not limited to, attorneys’ fees and collection agency fees. I consent to the exclusive jurisdiction and venue in Hennepin County, Minnesota. I consent to a minimum of a \$100 administrative charge if my account is sent to an attorney for collection.

Payment Authorization. I authorize AAAC to directly bill my health plan or third-party payer for services rendered to me by or on behalf of AAAC, and acknowledge that AAAC is not obligated to submit claims to third-party payers on my behalf unless required by law. I also authorize any third-party payer through which I may have benefits to make payment directly to AAAC for such services. I understand and agree that AAAC is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

Statement to Permit Payment for Medicare Benefits. If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to AAAC, for any services furnished to me by AAAC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine my benefits.

Notice of Privacy Practice

Confidentiality. It is the policy of Advancements in Allergy and Asthma Care, Ltd. (“AAAC”) to protect the privacy and confidentiality of patients’ medical information and to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Notice of Privacy Practice. AAAC’s Notice of Privacy Practices explains how AAAC may use and disclose my medical information. It also explains my rights regarding this kind of information. AAAC may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices upon request. AAAC’s Notice of Privacy Practices can be obtained by contacting the clinic.

Signature of Patient (or legal guardian): _____ Date: _____

Relationship to Patient If Guardian _____ Reason Patient is Unable to Sign _____