**ADVANCEMENTS IN ALLERGY AND ASTHMA CARE, LTD.**

Consent and Payment Authorization Form B”H

**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 and Payment Authorization Form and the conditions stated within.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## 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 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 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.

**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.

**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, but acknowledge that AAAC is not obligated to submit claims to third-party payers on my behalf unless required by law or by its contracts. 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 these benefits or benefits for related services.

Written Name of Patient (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient If Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason Patient is Unable to Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_