

Authorization to Release Information
And to
Pay Benefits to Provider
Please Read and Sign Below

A photocopy of this authorization may be used in place of the original

I hereby authorize Birmingham Allergy and Asthma Specialist, PC to release any medical or patient information acquired in the course of my examination to the insurance carrier(s)/Center of Medicare and Medicaid Services and its agents needed to determine these benefits payable for related services. I also authorize release of my medical information related to my symptoms/treatment to other health care providers when my provider refers me to them for specialty services.

In addition, I also hereby authorize payment of authorized insurance/Medicare benefits be made directly to Birmingham Allergy and Asthma Specialist, PC for the medical/surgical benefits if any, otherwise payable to me for his/her services. I understand the clinic charges may exceed insurance company/Medicare payment, and if greater than such, I will be responsible for paying that additional allowable amount.

I agree to pay for charges which may not be covered by my insurance. I understand that the following services may not be covered:

Influenza Medicine and Administration

As specified, I understand that, at any time, I may revoke this authorization of the release of my medical records. If I revoke this authorization, however, there may be difficulties in obtaining insurance payment for my treatment. In any event, I will assume complete responsibility for payment of all charges.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done.

I understand, whether I sign as an agent or as a patient, that whatever services are rendered, including allergy extract and injections, by Birmingham Allergy and Asthma Specialist, PC, to the patient, obligates me to assume financial responsibility, and I agree to pay upon request to Birmingham Allergy and Asthma Specialist, PC all charges for services incurred by the patient. If the account is referred to an attorney/collection agency for collection, I understand that I am responsible for attorney fees and collection expenses. I understand that all bills are payable upon presentation and that I, not the insurance company, am responsible for the payment of the services. This office will file and collect from insurance when insurance benefits are present. I hereby authorize Birmingham Allergy and Asthma Specialist, PC to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered.

If you have any questions regarding this notice or our health information policies, please contact:
Birmingham Allergy and Asthma Specialists, PC, Attn: Susan Wells, 3125 Independence Drive, Suite 100, Birmingham, AL 35209 or call (205) 943-1197 for further information.

SIGNATURE

SIGNATURE OF PARENT/LEGAL GUARDIAN

PRINTED NAME

PRINTED NAME

DATE

DATE