Consent to Treat

Acknowledgement of Notice of Privacy Practices

Consent to Treat and Insurance Assignment of Benefits

- I, or the undersigned acting on behalf of the patient, consent to medical care and treatment including but not limited to: diagnostic procedures, medical examinations and/or treatments by my attending physician(s), their assistants or designees, and or allied health professionals.

- I assign to Midwest Allergy and Asthma Clinic, P.C., subject to acceptance, all right, title to and interest in benefits payable. I authorize direct payment of all health insurance benefits to Midwest Allergy and Asthma Clinic, P.C. I agree to pay Midwest Allergy and Asthma Clinic, P.C. for charges not paid pursuant to this assignment.

Financial Agreement

- I understand that I the patient will be responsible for any balance due to Midwest Allergy and Asthma Clinic, P.C. that is not covered under my Insurance Policy. Example: Copays, Deductibles, Co Insurance and Non Covered procedures.

Receipt of Notice of Privacy Practices

- I have received or been offered a copy of Midwest Allergy and Asthma Clinic, P.C.'s Notice of Privacy Practices.

I have read, fully understand, and agree to the above information:

Signature_____ Date_____

Print Name_____ Patient Name (If minor) _____

Relationship to the patient:_____ Responsible Party DOB:_____

Medicare Patients Only

Medicare Authorization

I request that payment of the authorized Medicare benefits be made either to me or on my behalf to Midwest Allergy and Asthma Clinic, P.C. for any services furnished to me by the clinic. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable for related services. I also permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment as my secondary or supplement insurance company.

Signature _____ Date_____

Name of patients Secondary/Supplement Insurance_____

Medicare Secondary/Supplement Questionnaire

		Yes	No
1.	Is the patient a Veteran?.....	____	____
	a. Did the VA refer you here for treatment?.....	____	____
	b. Does the patient have a VA "fee basis ID card"?.....	____	____
2.	Do you have a Federal Black Lung Card?.....	____	____
3.	Is the medical condition due to an accident of any kind?.....	____	____
4.	Is the patient covered by any employer's health insurance plan through their own employment or that of a family member (not a retiree coverage).....	____	____