Consent of Treatment

Acknowledgement of Notice of Privacy Practices

Consent of Treatment

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.

Insurance Assignment of Benefits & Financial Agreement

I assign to Midwest Allergy and Asthma Clinic, P.C., subject to acceptance, all rights, 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 for charges not paid pursuant to this assignment.

Because each insurance plan has unique coverage and networks, I understand that the responsibility to confirm that the visit and additional services are covered is solely mine as the policy holder. It is not possible for the clinic staff to accurately determine ahead of time if the clinic is in my insurance's network, if services are covered, or what the balance may be.

I understand that testing and any other services provided during the visit will result in additional charges above the fee for the office visit.

I also understand that by signing below, I 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, coinsurance, and non-covered procedures. If I do not provide insurance, I will be responsible for the full balance. Unpaid and past due balances may result in discontinuation of care.

No-Show Policy

I also understand that failure to come for scheduled appointments or same day cancellations may result in discontinuation of care.

Receipt of Notice of Privacy Practices

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

If you are accompanying a minor or incapacitated adult:

*The parent/guardian of the minor or incapacitated adult is to complete this form. A signed waiver must be on file to complete paperwork for and accompany the minor/protected person that is not your charge.

Patient Name: ____

Patient DOB: ____________________ Relationship to Patient: ______________________

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

Signature: ________________________________ Date: ____________________

Print Name: _______________________________ DOB: ____________________

Address: ____

City: ___________________________ State: __________ Zip: ______________

Phone Number: _______________________ SSN: _________________________

Place of Employment: ____