

Organized Healthcare Arrangement

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by National Allergy, Asthma & Urticaria Centers of Charleston, P.A. and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases. I/we am/are aware that the practice of medicine is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have had read to me this consent and understand and agree to its contents.

(Initials)

Authorization for Release of Information and Assignment of Insurance Benefits

My physician is authorized to release any medical information required in the processing of applications or submission information for financial coverage. I/we also agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries – I/we provided all necessary information for proper assignment of Medicare/Medicaid benefits.

(Initials)

Agreement of Financial Responsibility

I/we guarantee payment of all charges associated with services received from National Allergy, Asthma & Urticaria Centers of Charleston, P.A. I/we agree to assign any insurance benefits or other funding to National Allergy, Asthma & Urticaria Centers of Charleston, P.A. I understand it is my responsibility to verify participation status of the physician with my health plan prior to the patient's visit and to obtain a authorization as required by my health plan prior to the patient's visit.

(Initials)

H.I.P.A.A. (Health Insurance Portability and Accountability Act) Notification

I acknowledge my receipt of a copy of the National Allergy, Asthma & Urticaria Centers of Charleston, P.A. Notice of Privacy Practices.

(Initials)

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility can only be revoked upon written notice. By signing below, I/we acknowledge that this consent form has been read in full and explained as necessary.

Date/Time

Signature of Patient (Parent or Legal Guardian)

Signature of Witness

Signature of Guarantor (if different from patient)