PATIENT AUTHORIZATION

Patient Financial Responsibility

Our goal at Allergy Associates of the Palm Beaches (AAPB) is to be up front with our patients about their costs prior to receiving care. It is the patient's responsibility to know and understand their health plan coverage and benefits. Our office will verify your benefit information, however, this is not a guarantee of payment. You are encouraged to contact your insurance company directly to verify your benefits and coverage prior to receiving treatment and services in the office. Any amounts quoted for "out of pocket" expenses are only an estimate and the exact amount of my financial responsibility will be made at the time the insurance company process the claim. Please contact our Billing Department with any questions.

We will file your insurance claim and accept assignment of benefits, however, having insurance is not a substitute for payment. Most insurance companies require patients to pay a portion of their doctor's fees. When using *out of network* insurance benefits, costs to the patient may be significantly higher than in network. My signature below indicates I will be financially responsible for all charges. All deductible, co-pay, or co-insurance amounts, or any other out of pocket expenses are collected at the time of the visit. You will be billed for any additional financial responsibility as determined by your carrier after the insurance claim is processed. Outstanding balances may be referred to an outside collection agency in the event of non-payment. I agree to pay all costs of collection.

It is ultimately the patient's responsibility to obtain a referral, if necessary, from their primary care physician. As a courtesy, our office will make a request for referral on your behalf. If we have no referral at the time of your visit, your appointment may need to be rescheduled.
(Please initial _____)

PLEASE ADVISE THE OFFICE OF ANY CHANGES TO YOUR INSURANCE, ADDRESS, PHONE, OR PCP

Authorization for Insurance Benefit Assignment

I authorize AAPB office to act as my agent in obtaining Medicare and/or insurance payments, and I request that payment of those benefits be assigned on my behalf to Allergy Associates of the Palm Beaches, PA. I authorize AAPB to use and disclose my health information, including AIDS related testing/treatment, psychiatric or substance abuse information, to the Centers for Medicare & Medicaid Service (CMS), their contractors, or other insurance carriers and their agents for the purpose of obtaining claim payments and determining insurance benefits. This assignment will remain in effect until revoked in writing. A copy of this assignment is considered to be as valid as the original.
(Please initial _____)

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name Witness

Discrimination is Against the Law-
Allergy Associates of the Palm Beaches, PA (AAPB) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex. AAB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Allergy Associates of The Palm Beaches cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Allergy Associates of The Palm Beaches no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

ATTENTION: If you need language assistance services, the office will provide free of charge. Please call 561-626-2006.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 561-626-2006