

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

AUTHORIZED REPRESENTATIVE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**FINANCIAL POLICY**

Idaho Allergy's financial policy is payment at the time of service. Any balance remaining over 60 days will be subject to a one-time \$20 fee & 12% annual interest by an outside billing service.

Idaho Allergy requests at least a 24 hour advance notice when cancelling or rescheduling an appointment.

\_\_\_\_\_ Initials of Patient/Authorized Representative (Must be over 18 for initials)

**MEDICARE AND INSURANCE AUTHORIZATION AND ASSIGNMENT**

Your insurance policy is a contract between you and your carrier. However, for your convenience, Idaho Allergy will submit your claim to your primary insurance company. Idaho Allergy participates with Medicare; therefore we will bill Medicare directly. The remaining balance after a Medicare payment is the patient's responsibility. In addition, Idaho Allergy may participate with other insurance companies; you are responsible for any co-pay, deductible or coinsurance at the time of service. Your insurance may require a preauthorization for services and/or treatment. It is ultimately your responsibility to know your plan's benefits and requirements and obtain the necessary authorizations or pre-certifications.

I authorize Idaho Allergy to release any information needed to my insurance carrier and/or Health Care Financing Administration, and its agents to determine benefits payable for related services. I hereby assign to Idaho Allergy all payments for medical services rendered to myself and/or my dependents.

Signature of Patient/Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_  
(Must be over 18 for signature)

**HIPPA CONSENT**

In signing this form, you consent to the use and disclosure of your protected health information by Idaho Allergy, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You have the right, and we encourage you, to review our NOTICE OF PRIVACY PRACTICES prior to signing this consent. It provides more detail on how we may use and disclose your information. The NOTICE OF PRIVACY PRACTICES may change at our discretion, as necessary. A copy may be requested when you are being seen as a patient or sent to your residence.

You may also revoke this consent, in writing. Information on treatment and services provided or prior consents may still be used for purposes of treatment, payment, or health care operations. Please refer to the NOTICES OF PRIVACY PRACTICES for further information.

Signature of Patient/Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_  
(Must be over 18 for signature)