MUNCIE ALLERGY CENTER, P.S.C.
HIPAA CONSENT

Patient Name ____

SSN:____________________ Date of Birth:_____________

PLEASE PRESENT YOUR INSURANCE CARD AT THE FRONT DESK.
A PHOTO COPY WILL BE MADE FOR OUR RECORDS.

CONSENT TO TREATMENT

I Consent to all medical care treatment, examinations, tests and surgical procedures determined by my physician or any physician or other personnel of Muncie Allergy Center to be necessary or advisable for me. I understand that there are no guarantees concerning the results of my care. If I refuse treatment that is recommended for me by my physician or any other physician or personnel of Muncie Allergy Center, I will not hold my physician or any other physician or personnel of Muncie Allergy Center responsible for any consequences, and I release them from liability. I acknowledge and agree that Muncie Allergy Center, its physicians, employees and agents are not responsible or liable if any individual or entity to whom Muncie Allergy Center releases medical or financial information discloses that information without my written consent or authorization.

CONCERNING INSURANCE PAYMENT

Our fees reflect our service, not an insurance company's reimbursement schedule. Certain insurance companies may choose not to pay your medical fee in full. This is not uncommon and is unfortunate for those affected by this problem. If your insurance rejects a reimbursement level, which is below our standard fee, the responsibility of the remainder of the payment is the patient responsibility when applicable.

FINANCIAL RESPONSIBILITY

Unless other arrangements satisfactory to Muncie Allergy Center have been made, I hereby guarantee payments in full within (30) calendar days of all charges established at Muncie Allergy Center for services rendered to me. Any account requiring collection work by Muncie Allergy Center after the 30 days may be charged 1/3rd of the balance owed or $25.00 whichever is greater. All accounts referred for collection may include any charges that a third-party Payer may determine to exceed usual and customary limits. I understand and agree that if I do not meet all my payments responsibilities I will be responsible for all collection agency fees, reasonable attorney's fees and court costs incurred by Muncie Allergy Center. I understand that I may be charged interest on any unpaid balance at the rate of 1 ½% per month. When applicable, our billing staff will assist you in working a payment schedule. The payment will be based upon the anticipated payment from the insurance company.

Date: _____________ Patient/Guarantor Signature: ________________________

AUTHORIZATION TO FILE CLAIMS AND & FOR PAYMENT OF BENEFITS

I authorize the release of the medical information necessary to process any claim for services provided by Muncie Allergy Center that are due as a result of treatment or care provided by Muncie Allergy Center to me or my dependents. I understand that Muncie Allergy Center is acting solely as an agent in filing for insurance benefits assigned to it and cannot guarantee such payment. No guarantees have been made that insurance or health plan benefits will be paid for services rendered. I understand the Doctor's charges may exceed the insurance carrier's allowable payment. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MUNCIE ALLERGY CENTER FOR CHARGES NOT PAID BY MY INSURANCE COMPANY OR HEALTH PLAN WHEN APPLICABLE.** In the event health plan benefits are paid directly to me, I agree to provide these payments to Muncie Allergy Center.

Signed: ________________________ Witness:____________________________

Patient's Date of Birth: _____________ Date: ____________________________

Policy Holder Date of Birth: _______________ Staff Initials: ___________

MUNCIE ALLERGY CENTER, P.S.C.

Patient Name: ____

SSN: _________________________________Date of Birth: ______________________

CONSENT FOR TELEPHONE INFORMATION

Please indicate your preference for Muncie Allergy Center leaving specific health information on your telephone answering machine. This information is updated annually unless the patient requests a change sooner than the annual insurance renewals date.

_____ I **DO NOT** want health information left on my telephone answering machine.

_____ I **DO** request my health information to be left on my telephone answering machine.
Patient/Legal Representative Signature _______________________ **Date:** ___/__/___

_____ **If I** am not available by telephone, please leave my health information with: ________________

____________ Patient/Legal Representative Signature: __________________ Date: ___/__/__

NOTICE OF PRIVACY PRACTICES

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available upon request and it is posted on our bulletin board in the waiting room at Muncie Allergy Center. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

SIGNATURE

I, The undersigned, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and health care operations.

Signature: ____________________________________ Date: ____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to the Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include completed Consent in patient chart.

Staff Initials: ___