GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

Patient's Name:
Patient's Date of Birth:

1. **Consent:** I, the undersigned patient or authorized representative of the patient, hereby voluntarily request, consent to, and authorize Asthma, Allergy & Immunology Center ("Practice") and its staff to provide medical care including treatments, examinations, diagnostic procedures, and the administration of medications as deemed necessary and advisable by the Practice and its healthcare providers to me.
2. **Release of Information.** I hereby authorize the Practice to release and to disclose to any third party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my patient records as is necessary in order to receive reimbursement for any healthcare services rendered to me by the Practice. I also authorize release and disclosure of my patient records to other healthcare providers who may, in the opinion of the Practice, be of assistance in providing treatment or the most appropriate medical care to me.
3. **Physician Referral:** I understand that if my health insurance is provided by a managed care plan, I am responsible for contacting my primary care physician and obtaining necessary referrals for any services rendered at this office. Failure to do so will result in my being financially responsible for said services.
4. **Payment:** I understand that I am responsible for any health insurance deductibles and/or co-payments. I understand that I am financially responsible for the cost of services at the time they are rendered unless prior arrangements have been made. I understand that if my medical insurance plan (or other third party benefit plan) denies payment of services or the services are not covered services under such plan, I will be responsible for payment of said services and I agree to pay all charges submitted by the Practice for the care given to me. I authorize my medical insurance plan (or other third party benefit plan) to make payments directly to the Practice for any services the Practice furnishes to me.
5. **Accuracy & Integrity:** I hereby acknowledge the information I provided on the patient information form and patient history to be true and correct and completed to the best of my ability.
6. **No Guarantees:** I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees are made as to the result of the care and treatment which I have hereby authorized.
7. **Contact Authorization:** ***I ____do ____do not*** (*check one*) authorize information to be left on my voice mail.

We will ordinarily contact you using your home phone number and home address. If you want us to contact you in another manner, please provide us with specific instructions about how we may contact you.

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I have read this form or it has been read to me and I am satisfied that I understand the entire contents and significance of this form, and all my questions (if any) have been answered. Further, I understand that this consent will be deemed continuing and I am free to revoke my consent at any time.

Date of Visit: ______________ Signature of Patient/Guardian: ______________________________________

If patient is unable to consent, please complete the following:

Patient is a minor ___________ years of age

Patient is unable to sign because:

____

Note: To be filed and retained for a minimum of seven (7) years

Please return forms with the insurance card(s) to the receptionist. Thank You