Ashburn Allergy

REQUEST FOR TREATMENT AND INSURANCE CERTIFICATION

This is to certify that I,_____authorize Ashburn Allergy, PLLC to file claims to my insurance company(s) for services rendered to me by Ashburn Allergy, PLLC. I certify that the information I have reported with regard to my insurance company and my health insurance plan is correct. I understand that I am responsible to notify Ashburn Allergy, PLLC if my insurance company changes, benefits are terminated or if the coverage I have reported is incorrect. I understand and agree that it is my responsibility to understand the benefits of my insurance plan and that failing to do so may result in lesser payment or no payment at all from my insurance carrier(s). I understand and agree that I am ultimately responsible for payment in full for all services that I have received from Ashburn Allergy, PLLC. I also agree that should it become necessary to collect these charges through an attorney or other collections process, I shall be responsible for any and all court, legal and late fees.

If a referral is required, I understand that it is MY responsibility to obtain all documentation required by any insurance carrier or reimbursing agent in order to determine payable benefits.

_____ Patient/Guardian Initials

PAYMENT AT TIME SERVICES ARE RENDERED

I understand that payment of an Estimated Bill will be expected at the times services are rendered. I understand that my Estimated Bill will be provided prior to leaving the office and will detail my expected out-of-pocket charges based on Ashburn Allergy, PLLC's contractual fee schedule with my insurance carrier and the details of my particular insurance plan. The Estimated Bill will detail all deducible, co-pay, and co-insurance expected to be owed out-of-pocket by me to Ashburn Allergy, PLLC as those fees are not covered by my insurance plan. It is anticipated that my Explanation of Benefits (EOB) will detail these charges after submission of my claim and also detail those fees that are covered under my health insurance plan. My estimated payment could potentially result in an under-payment or overpayment based on my insurance carrier's determination of the filed claim. If an under-payment occurs, I understand that I will be billed for the remainder owed. Ashburn Allergy, PLLC will issue a prompt refund for any overpayment that is made by me after the claim is processed.

_____ Patient/Guardian Initials

LIFETIME RELEASE OF INFORMATION AND PAYMENT RESPONSIBILITY

I authorize Ashburn Allergy, PLLC to release any information, including medical information for claims to my insurance company(s) or reimbursing agency, or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration, in order to determine benefits to which I may be entitled. I hereby authorize payment be made directly to Ashburn Allergy, PLLC, realizing that I am responsible to pay any deductible, copay, co-insurance or non-covered services as determined by my insurance company. In the event the account must be placed with an attorney or collection agency to obtain payment from me, I shall be responsible for all attorney and collection fees incurred.

I may revoke this authorization at any time in writing. In the case of Medicare Coverage, the Social Security Administration may revoke this authorization at any time in writing.

_____ Patient/Guardian Initials

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices and I have been provided the opportunity to review the document.

_____ Patient/Guardian Initials

I have fully read and initialed the information in each section above, and with my signature below, agree to the terms and conditions listed in each section above.

_____ _____

Signature of Patient/Guardian Date

Print Name of Guardian (if patient is a minor): _____ Relationship to Patient: _____