TWO RIVER ALLERGY & ASTHMA GROUP, LLC
HIPAA COMPLIANT – PATIENT CONSENT FORM

Patient Name:_____ DOB:_____

Address:_____ City:_____ State:_____ Zip:_____

SSN#:_____ Home#:_____ Cell#:_____

Work#:_____ Employer:_____

Referring/PCP Doctor:_____ Phone#:_____

Pharmacy Name:_____ Phone#:_____

Address:_____ City: _____ State: _____Zip:_____

Emergency Contact:_____ Phone#:_____ Relationship:_____

INSURANCE INFORMATION – PLEASE HAVE YOUR INSURANCE CARDS READY FOR PHOTOCOPYING

Primary Insurance:_____ Name of Insured:_____ DOB:_____

Policy #:_____ Group #:_____

*Guarantor Name: _____ DOB:_____ Relationship:_____

Address:_____ Phone#:_____

Secondary Insurance:_____ Name of Insured:_____ DOB:_____

Policy #:_____ Group #:_____

*Guarantor Name: _____ DOB: _____ Relationship:_____

Address:_____ Phone#:_____

NOTE: If your insurance requires a referral for you to see our doctors, it is your responsibility to provide our office with the referral. If your insurance company denies payment-due to no referral, you the patient agree to pay our doctors in full for any charges incurred during your visit.

Patient or Guardian Signature _____ Date _____

INSURANCE RELEASE INFORMATION: I hereby authorize Two River Allergy & Asthma Group LLC to release information needed to file and expedite payment on my claim. I assign any benefits payable on my behalf to Two River Allergy & Asthma Group LLC to my insurance company. I hereby give permission for my insurance company to pay Two River Allergy & Asthma Group directly. I realize I am responsible for my copays, coinsurances and any deductibles or amount indicated on my explanation of benefits as patient responsibility. If I do not give this office current insurance information, I am responsible for the bill. If my account is sent to collection, I realize that I am responsible for the collection fees. A $50.00 fee will be charged for a missed office visit and $20.00 for an immunotherapy injection which has not been cancelled within 24 hours. There will be a fee of $1.00 per page plus misc. cost for records. There will be no charge for records to be sent to another doctor.

Patient or Guardian Signature _____ Date _____

Authorization for Disclosure of Protective Health Information:
I authorize my physician and/or administrative staff to disclose the following protected information to: _____myself, _____ spouse, significant other, or parent _____
Check your choice of information to be disclosed:

- ☐ Yes, I give permission for medical information to be left on my answering system
- ☐ No, I do not give permission for medical information to be left on my answering system

If yes, please check: _____Laboratory tests _____ Diagnosis _____ Advice (Rx, Medical Advice etc.)

I, _____ have received a copy of this office's Notice of Privacy Practice. This authorization shall be effective until January 1, 2021. I understand that I have the right to revoke this authorization in writing to Two River Allergy & Asthma Group LLC. I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy rule or State Law.

_____ _____
Signature of patient or personal representative Date

_____ _____
Print name of patient or personal representative Date