

Patient Name: _____

DOB _____

Please Print

Cincinnati Allergy & Asthma Center

PAYMENT AGREEMENT

Regardless of insurance benefits, or the designation of some other responsible party on the registration form, I understand that I am financially responsible for the fees. I understand I am responsible to know if I am covered by my insurance and if CAAC is a provider. If I am covered by Medicare, I understand that if I am provided specific written notice in advance that Medicare is not likely to cover a particular visit or procedure, I will be responsible for payment of that procedure or visit if I agree to proceed. Although CAAC will take reasonable steps to obtain reimbursement from the insurance company or the persons listed on the registration form as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financially responsible party. Further, in the event of payment default, I agree to pay all collection costs in excess of the initial fee (including any legal expenses) and, at the option of CAAC, a reasonable charge for late payments.

AT THE TIME OF THE VISIT, I understand it is my responsibility to obtain a current referral (if required) and pay any **deductibles, co-payments,** and/or **coinsurance** not covered by the insurance plan or a government program. I understand that I will be billed **\$5** to cover invoicing cost for each visit for which I do not pay my portion at the time service is rendered. Further, I authorize CAAC to file claims on my behalf for covered services and assign all insurance or other payer benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original. For missed appointments, there is a **\$20** fee unless the appointment has been cancelled at least 24 hours in advance.

I have read and I understand this document.

Patient/Parent/Guardian Signature: _____ Date: _____

Patient Name: _____
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RELEASE OF INFORMATION

Practice Philosophy on Patient Privacy

The Cincinnati Allergy & Asthma Center (here forward referred to as "CAAC") recognizes the importance of patient privacy. As such, it is the policy of the CAAC to treat all medical information as confidential and absent extraordinary or emergency circumstances; CAAC will not disclose a patient's medical information without appropriate patient consent.

Before consenting to the release of medical information, each patient has the right to review the written Notice of Privacy Policy of CAAC, which gives a more complete description of CAAC's policies on the use and disclosure of patients' medical information. Each patient may obtain a copy of such Notice upon request. CAAC reserves the right to change its Notice of Privacy Policy and all patients have the right to receive an amended copy of the Notice upon request.

Also, each patient has the right to request in writing that CAAC restrict how protected and private medical information is used or disclosed to carry out treatment, payment, or other health care operations. Please note that CAAC is not required to agree to such requested restrictions, but if it does, the restriction will be binding upon this practice. Additionally, CAAC may refuse to treat any patient who refuses to consent to the use and disclosure of medical information for treatment, payment, or other health care operations purposes.

Patient Consent for Use and Disclosure of Medical Information To Carry Out Treatment, Payment, and Health Care Operations

I consent to the release of information regarding services rendered by CAAC to my insurance company or any governmental payer of the medical expenses as listed above, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of all medical information (including - but not limiting - doctors notes, labs, pictures of ailments, etc) to my family physician and other treating physicians/laboratories, as listed by me above, as well as to any physicians to whom CAAC may refer me for purposes of further treatment/diagnosis. I consent to the use and/or release of medical information about me for purposes of health care operations, as it relates to CAAC's internal practices and general administrative activities. In addition, if the patient is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person (s) that I have listed above as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including, but not limited to, electronic mail ("email") and facsimile.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that CAAC has taken action in reliance upon my consent.

Patient/parent/Guardian Signature: _____

Date: _____