Allergy Asthma Ear Nose & Throat

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The purpose of this form is to inform you about medical insurance, eligibility, cover and our policy regarding payment for medical services.

1. All insurance policies are different and coverage of medical benefits can change without warning.
2. We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
3. You are personally responsible for knowing and understanding your own insurance policy, coverage, and benefits.
4. Not all insurance companies or third party payers pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
5. All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
6. You are financially responsible for payments of all non-covered procedures or services, including but not limited to Allergy Injections and Allergy Testing.
7. In the event of ineligibility for coverage of plan benefits, as well as non-authorized or non-covered procedures or services, you understand you are fully financially responsible for payment.
8. If you have questions about your insurance, we are happy to be of assistance. Specific coverage however, should be directed to your insurance company.

We at Allergy Asthma Ear Nose & Throat. firmly believe that a good patient-physician relationship requires understanding and good communication. Please sign below, indicating you have read, understand, and agree to this financial agreement with Allergy Asthma ear Nose & Throat

___________________________	___________________
Print Name of Patient	Date
___________________________	___________________
Signature of Patient or Guardian	Date