Notice To All Patients

Please be very careful when filling in the insurance information, our office uses it to file your insurance. Please inform our office if your insurance changes at any time so that we may file accordingly. Our office will NOT be responsible for claims paid at an incorrect rate if you have provided us with improper information.

Name of Primary Insurance Company:_____

Policy Holder (Employer Name):_____

Subscriber (Employee Name):_____

Subscriber SSN#:_____ Group Number :_____Policy #:_____

Claims Address:_____ Insurance Co. Phone:_____

In Case of Emergency, Contact:_____ Relationship:_____

Day Phone:_____ Evening Phone:_____

How did you hear about Vital Allergy & Asthma Center?_____

Referring Doctor:_____ Address:_____

Primary Care Doctor:_____ Address:_____

Please Send Consultation Report To:_____

*I HAVE RECEIVED A COPY OF THE PRIVACY POLICY OF VITAL ALLERGY & ASTHMA CENTER AND HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICAL FACILITY, OR IT'S REPRESENTATIVE, TO RELEASE ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTION, OR TREATMENT AND COPIES OF ALL MEDICAL RECORDS TO VITAL ALLERGY & ASTHMA CENTER, PA. I ALSO AUTHORIZE VITAL ALLERGY & ASTHMA CENTER, PA, ITS PHYSICIANS AND PROVIDERS TO RELEASE MEDICAL RECORDS TO THE INSURANCE COMPANY THAT IS RESPONSIBLE FOR MY HEALTH COVERAGE SHOULD IT BE NECESSARY FOR PAYMENT OF SERVICES PROVIDED. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Signature:_____ Date:_____
*THIS AUTORIZATION IS GOOD FOR ONE YEAR FROM DATE OF SIGNATURE

I HEREBY ASSIGN BENEFITS AND AUTHORIZE PAYMENT TO GO DIRECTLY TO VITAL ALLERGY & ASTHMA CENTER, PA FOR ANY MEDICAL SERVICE PROVIDED, BUT NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGE FOR THESE SERVICES. I AGREE THAT THE DOCTOR MAY RECEIPT FOR ANY SUCH PAYMENT AND THAT THIS RECEIPT SHALL BE A CONCLUSIVE ACKNOWLEDGEMENT BY ME THAT I HAVE RECEIVED BENEFITS FROM THE INSURANCE COMPANY ALL THE SUM SPECIFIED IN SUCH RECEIPT AND AGREE THAT SUCH PAYMENT SHALL DISCHARGE THE SAID INSURANCE COMPANY OF ANY AND ALL OBLIGATIONS UNDER THE POLICY TO THE EXTENT OF SUCH PAYMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTOR FOR ALL CHARGES NOT COVERED BY THIS AGREEMENT.

Signature:_____ Date:_____
*THIS AUTHORIZATION IS GOOD FOR ONE YEAR FROM DATE OF SIGNATURE