

ST. PAUL ALLERGY & ASTHMA CLINIC, P.A.

PATIENT CONSENT FORM

DATE: _____

PATIENT NAME: _____ PATIENT DOB: _____

Please read the following carefully and sign and date where indicated. Please ask if you have any questions.

CONSENT: I hereby consent to treatment by St. Paul Allergy & Asthma Clinic, P.A.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to St. Paul Allergy & Asthma Clinic P.A. for any services furnished me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

AUTHORIZATION FOR BILLING PURPOSES: I hereby authorize the release of information, including medical and billing information to be used and disclosed to carry out payment by St. Paul Allergy & Asthma Clinic, P.A., to include but not limited to my insurance company, third party payors, state medical assistance agency, or private agencies necessary for collection of payment.

ASSIGNMENT OF BENEFITS: I Hereby authorize payment of medical benefits to St. Paul Allergy & Asthma Clinic, P.A. for services rendered to myself and/or dependents.

If you do not sign this Consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you.

You have the right to revoke this consent, in writing except where St. Paul Allergy & Asthma Clinic, P.A. has already made disclosures.

We have given you a copy of our Notice Of Privacy Practices. If you have any concerns, please contact our Privacy Officer at 651-698-0386.

SIGNED: _____ DATED: _____

IF NOT PATIENT INDICATE RELATIONSHIP TO PATIENT: _____