

**Family Allergy & Asthma**

**Assignment and Release**

I, the undersigned certify that I (or my dependent) have health insurance coverage with \_\_\_\_\_ insurance company and assign directly to Dr. Michael Wein all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Notice of Privacy Practices**

I, the undersigned certify that I have received a copy of the privacy practices of this office, as required by law.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Consent & authorization to release medical information (choose one)**

YES, I have authorized Dr. Wein and staff to release medical information regarding my healthcare to friends and family that I have listed below.

NO, I do not authorize Dr. Wein and staff to release medical information regarding my healthcare.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Collection Policy**

I, the undersigned am advised that effective January 1, 2005, any account that becomes delinquent and is turned over to a collection agency may be applicable to a service charge of 25% of the delinquent balance.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

