STATEMENT OF FINANCIAL RESPONSIBILITY

As a courtesy to you, our office will submit claim(s) to your Health Insurance Carrier(s) for the services provided to you or your covered family members.

You will be responsible for any and all Co-Payments, Deductibles and for charges not covered by your health insurance carrier(s). All payments are due during the time of service based on available information.

If no payment is received from your insurance carrier(s) within 90 (ninety) days from the date of service, the bill becomes your responsibility. Our office will bill you for the amount owed. In the event your insurance carrier(s) denies payment to the claim(s) or pays only partial payment, the bill becomes your responsibility.

In the event your insurance carrier(s) send payment to you directly, you agree to pay that amount immediately to our office.

Should the account be referred to collection procedure, the undersigned shall be responsible for collection costs and attorney fees.

OUR OFFICE POLICY CONCERNING APPOINTMENTS

Dr. Vedere limits the number of appointments she makes on a daily basis, so that she can spend adequate time with each patient to provide the highest quality of medical care. Short notice cancellations, no shows, and rescheduled appointments significantly impact the schedule. We always call to confirm your appointment, which should be sufficient time to know if you can keep your scheduled appointment or not.

Broken appointments, cancellations with short notice, and no shows prevent us from providing our services to the patients in real need during those times. There have been several no shows and cancelled appointments in the past, which forced us to bring the following policy into effect:

If you are late without notification, we will have to reschedule your appointment at the next available time.

There is a fee associated for any changes in appointments with less than 24 hour notice and/or broken appointments without notice or for no shows

PATIENT CONSENT: MESSAGES AND APPOINTMENT REMINDERS PER HIPAA REGULATIONS

May we leave the following types of messages at your home/work/cell phone or emergency number?

1. Office appointment changes/reminders Yes { } No { }

2. Prescription refill information Yes { } No { }

3. Lab and/or test results/appointments Yes { } No { }

4. When authorization, medical records or physician script are required for upcoming appointment Yes { } No { }

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE

As required by the Privacy Guidelines, I hereby acknowledge that I have received a current copy of Allergy Specialist of the palm Beaches "Notice of Privacy Policy", revision dated April 14, 2003. I have read the Privacy Policy and understand my rights contained in the notice.

By signing on this form, I provide Allergy Specialist with my authorization and consent to use and disclose my information/my child's/ the patient for whom I am the legal guardian's protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy.

I hereby read and agree with STATEMENT OF FINANCIAL RESPONSIBILITY, OUR OFFICE POLICY CONCERNING APPOINTMENTS, PATIENT CONSENT: MESSAGES AND APPOINTMENT REMINDERS PER HIPAA REGULATIONS and ACKNOWLEDGEMENT OF RECIEPT OF NOTICE as described above:

Patient's Name: ____

Today's Date:_____________

(Please Print)

____

____

Patient/Parent/Legal Guardian's Name (Please Print) Patient/Parent/Legal Guardian's Signature

Authorized Facility Signature: ____

Today's Date:_____________