Patient Agreement

1. Consent to Treat. I hereby authorize North Mississippi Allergy and Asthma Center and its employees to examine me/the patient named below and to furnish diagnostic services as they deem necessary and appropriate.

2. Consent to Treat on Behalf of another patient. If I am authorizing on behalf of someone other than myself (a child, an individual with whom you are guardian/Power of Attorney) such examination and services may be provided in my absence only if deemed necessary and appropriate.

3. Financial Responsibility. I understand I am responsible for all services rendered at the physicians' regular rates.

    - If my insurance benefits are assigned to the physicians and billed to the insurance, I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer.
    - I understand and agree it is my responsibility to obtain any prior approvals required by my insurer, and to take all steps to qualify for insurance coverage.
    - I agree that all charges are due upon billing.
    - I agree that if my account if referred to a collection agency, the balance must be paid in full before new treatment will rendered.
    - If North Mississippi Allergy and Asthma Center provides me additional time or leniency in payment, this will not waive or release my financial obligation under this agreement.
    - If my Medicaid benefits are inactive, I have a choice to pay for the visit charges or reschedule my/child's appointment.

4. Assignment of Benefits. I allow North Mississippi Allergy and Asthma Center to revieve payment of insurance benefits for services provided by the physicians or agents.

5. Authorization for Release of Medical Information. I hereby authorize North Mississippi Allergy and Asthma Center to release a copy of any and all protected health information concerning my treatment to my insurance company. I further authorize the release of my protected health information concerning my treatment/illness to other physicians or facility that are involved in my case.

6. Divorced Patients. Our office policy regarding a child of divorced parents is as follows: The parent who brings the child to the office for care by our physician is the party responsible for the doctor's fee. Any arrangement that must be made between the two parents concerning payment is the responsibility of the parents, NOT our clinic.

7. Notice of Privacy Practice Acknowledgment. I acknowledge that I am aware of the HIPPA Privacy Act and will ask for a copy from North Mississippi Allergy and Asthma Center if desired.

8. School Forms. I authorize North Mississippi Allery and Asthma Center to furnish my child's school with plans pertaining to his/her allergy and asthma condition. I also authorize communication between the school nurse and our clinic.

9. Lab Billing. I acknowledge that North Mississippi Allergy and Asthma Center does not process labs and that I will receive a separate lab bill from North Mississippi Medical Center if blood work if obtained.

Printed Name of Patient: ______________________________ DOB: ________________

Signature of Patient or Authorized Person: ____

Relationship to Patient: ______________________ Date: __________________________