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Diplomate, American Board of Allergy and Immunology

Infants, Children and Adults

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## BENEFICIARY SIGNATURE FORM

THIS FORM WILL ALLOW THIS PROVIDER TO FILE CLAIMS  
WITH YOUR INSURANCE CARRIER WITHOUT YOUR SIGNATURE  
BEING REQUIRED ON EACH INDIVIDUAL CLAIM FORM

### PLEASE READ BEFORE SIGNING

As a courtesy we will file services rendered to your insurance carrier. All services excluding allergy shots are filed weekly. Shots are filed monthly. All patients are expected to pay applicable co-pays, coinsurances, and deductibles at time of service unless other arrangements are made. Any non-covered services will be your responsibility. This office cannot accept responsibility for negotiating a settlement on a disputed claim. You are ultimately responsible for payment of your account. If your insurance carrier has not responded within 90 days we will contact them in case of misdirected mail, etc. You will receive a statement each month if you have a patient balance, this excludes any balance pending with insurance. Please call us if you have any questions regarding your bill.

### PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

### INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to the above listed physician or supplier for services rendered.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT \_\_\_\_\_ D.O.B. \_\_\_\_\_