Patient Correspondence Information

Patient's Name: _____
Date of Birth: _____

Please list the person or people with whom we may inform about laboratory and X-ray results, general medical condition, diagnosis, appointments, prescription drugs, or other health care information. An example would be parents, grandparents, etc.

Name: _____ Phone #: _____
Name: _____ Phone #: _____
Name: _____ Phone #: _____

Please print the email address where you would like your billing statement and/or correspondence from our office to be sent.

_____

Can confidential messages (lab results, etc) be left on your telephone answering machine or voice mail?

___ Yes ___ No If yes, Phone #: _____

I am fully aware that a cell phone is not a secure and private line.

To optimize the patient's health care, we share information (labs, X-rays, etc.) concerning the patient with the patient's Primary Care Physician.

Primary Care Physician: _____
Address: _____ City, State: _____
Phone #: _____

I hereby agree to pay for services rendered to me at Dearborn Allergy & Asthma Clinic, PC. I authorize my insurance benefits to be paid to Dearborn Allergy & Asthma Clinic, PC. I realize that I am financially responsible for charges not covered by this assignment, services which may be considered by my insurance plan to be non-covered or included in another service, or charges for services with an appropriate referral/authorization by my primary care physician when required by my insurance. I hereby authorize the release of any pertinent medical information to insurance carriers.

Patient/Parent or Guardian Signature: _____ Dare: _____

4/2012