Insurance Information

Patient Name: _____ Today's Date: _____
First Middle Last

(Primary Insurance)

Name of Insurance Company: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____

Group #: _____ Policy / ID #: _____

Effective Date of Coverage _____

(Secondary Insurance)

Name of Insurance Company: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____

Group #: _____ Policy / ID #: _____

Effective Date of Coverage _____

Please remember you are responsible for all fees, regardless of insurance coverage.

Signed: _____ Date: _____
Patient or Legal Guardian

I authorize the release of any medical information necessary to process this claim.

Signed: _____
Patient or Authorized Person

Date: _____

I authorize payment of medical benefits to Allergy & Asthma Clinic of Alexandria, a Medical Corporation.

Signed: _____
Insured or Authorized Person

Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Louisiana Allergy & Asthma Specialists Privacy Practice Notice that describes how information about me may be used and disclosed. At my request, I can receive a copy of this notice.

Signed: _____ Date: _____

I authorize the following people to be a part of my healthcare management (to receive information regarding my medical care, lab or test results, and information regarding my account.)

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____