

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.

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

Signed: \_\_\_\_\_  
                    Patient or Authorized Person

Signed: \_\_\_\_\_  
                    Insured or Authorized Person

Date: \_\_\_\_\_

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: \_\_\_\_\_