



JOHN V. BOSSO, MD, FAAAAI, FAAAAI

LOURDES B. deASIS, MD, MPH, FACP, FAAAAI

## PATIENT INSURANCE WAIVER

I \_\_\_\_\_ have requested treatment from the Allergy & Asthma Consultants. I agree that I am responsible for all charges incurred for any visit. I understand I will be responsible for payment **if:**

- I am not insured with a participating insurance plan
- I do not provide the necessary insurance referral from my PCP on the day of my visit, if required by my plan.
- I do not provide the correct insurance information to the office
- My insurance plan has been canceled
- My insurance does not cover the services rendered
- If I don't comply with my insurance co. request for information (as an example, full time student status, other insurance information )

I am aware that some insurance companies might not cover Nasal Smears and Rhinometry tests. Therefore, I have agreed before receiving the service to pay for it myself.

**Patient Signature** \_\_\_\_\_ **DATE** \_\_\_\_\_

### Authorization Of Payment

I hereby authorize payment for all medical benefits directly to Allergy & Asthma Consultants Of Rockland & Bergen P.C. (P.A.)

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness Signature** \_\_\_\_\_ **Date** \_\_\_\_\_