Limits of Confidentiality

By signing below you are authorizing both treatment and the release of medical health information necessary to process you insurance claims. You are also authorizing the release of your medical information to referring doctors and insurance companies on behalf of Grand Traverse Allergy, P.C. If applicable, this authorizes us to bill Medicare and release any information needed to determine payment for any specific date of service.

I wish to be contacted in the following manner (check all that apply):

____ Home telephone # __________________
- ___ OK to leave a message with detailed information
- ___ Leave message with call-back number only

___ Work telephone # ____________________
- ___ OK to leave a message with detailed information
- ___ Leave message with call-back number only

___ Written Communication
- ___ OK to mail to my home address
- ___ OK to fax to this number

___ Other _________________________

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Financial Policies

1. It is our office policy for you to pay your co-payment at the time of service unless prior payment arrangements have been made. Payment methods available are cash, check MasterCard or Visa. Please check with your insurance company on co-pay amount.
2. We participate with **BCBS, Medicare, Priority Health, Tricare, PPOM, Preferred Choices & some Medicaid policies**. We will file most other primary insurances as a courtesy to our patients. You are responsible for all balances not paid by the insurance company. Secondary insurances will only be filed if we participate with them. If you are not sure, please ask the receptionist.
3. It is your responsibility to request that any needed insurance referrals be completed by your primary care physician before being seen at our office. Please check with your primary care physician or insurance company to see if this has been done before your appointment.
4. Please bring your current insurance card/Medicaid card with you to each visit so that we may file it for you. The insurance will not be filed until we are provided with a copy of the card. **If your insurance changes retroactively to something that we do not participate with, you will be responsible for payment in full at that time. Initial ___________**
5. It is your responsibility to check insurance coverage for procedures done at our office before appointments.
6. Some charges are not covered or are covered only in part by the insurance company. You are responsible or any balances not paid by the insurance company including co-pays, deductibles and non-covered services.
7. In the event that any of the information provided by you on the front side of this form changes, please contact our office to update our records to avoid confusion in billing. It would be greatly appreciated!

I have read and understand the above statements and received the Notice of Privacy Practice regarding my protected health information at Grand Traverse Allergy, P.C.

Signature of Patient ____**Date** _____________________________

Signature of Parent or
Legal Guardian (if a minor)____ **Date** _____________________________

Witness ____ **Date** _____________________________