Medical Insurance Information

We are committed to provide you with the best possible care. If you have medical insurance, we are anxious to help you receive you maximum allowable benefits. In order to achieve these goals, we need your assistance and you understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept checks, cash, Visa, and Mastercard. We will gladly discuss your proposed treatment and answer and questions relating to your insurance.

Please realize that:

1) Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2) Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. If your insurance company does not pay within 30 days, you may authorize us to file a complaint with the Insurance Commissioner.

We must emphasize that as medical care providers, our relationship is with you, NOT your insurance company. All charges are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of you account. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us.

Patient: _____ Date: _____

Responsible Party: _____ Date: _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____

to pay and hereby assign directly to Allergy & Asthma Associates all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Allergy & Asthma Associates will be credited to my account, in accordance with the above assignment.

Authorized Signature: _____ Date: _____

Patient Information Form

PATIENT:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

Date of Birth: _____ Sex: M_____ F_____ Martial Status S____ M____ D_____

SS#: _____ Employer: _____ Student: _____

E-Mail address: _____

RESPONSIBLE PARTY (If different from the patient)

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

Date of Birth: _____ Sex: M_____ F_____ Martial Status S____ M____ D_____

SS#: _____ Employer: _____ Student: _____

E-Mail address: _____

Spouse/Parent Name: _____ Home Phone: _____

SS#: _____ Date of Birth: _____ Work Phone: _____

Employer: _____ Cell Phone: _____

In Emergency Notify: _____ Phone: _____

How did you learn of our practice? _____ by Dr. _____

INSURANCE INFORMATION;

Carrier #1: _____

Address: _____

Policy #: _____ Group#: _____ Plan#: _____

Subscriber: _____ Date of Birth: _____

Address: _____

SS#: _____ Employer: _____

Carrier #2: _____

Address: _____

Policy #: _____ Group#: _____ Plan#: _____

Subscriber: _____ Date of Birth: _____

Address: _____

SS#: _____ Employer: _____

My signature on file below signifies that this medical office has my permission to provide to the above carriers any information necessary for the processing of my insurance clam.

Signature: _____ Date: _____

ALLERGY & ASTHMA ASSOCIATES

5424 19TH STREET, STE. #300
LUBBOCK, TEXAS 79407

TELEPHONE: (806) 795-4391
WWW.DRMAMLOK.COM

ROBERT J. MAMLOK, M.D.
DIPLOMATE, AMERICAN BOARD OF
ALLERGY & IMMUNOLOGY

Privacy Notice Acknowledgement

The Federal Government has passed laws regarding the privacy of medical records. This is known as the Health Insurance Portability and Accountability Act (HIPAA). We have followed their guidelines by creating an office policy to help safeguard the privacy of your medical records. We would be glad to share a copy of this policy with you. This form indicates that you have been given the opportunity to review this policy if you wish to do so.

I have received Allergy and Asthma Associates' notice of Privacy Practices

_____
Patient Name

_____ ____/____/_____
Signature of Patient or Guardian Date