Thank you for choosing our practice. We are committed to providing you with quality and affordable healthcare. Below is information regarding our privacy policy, consent for treatment and payment policy as it relates to patient and insurance responsibility for services rendered. Please review it, then sign/accept in the space provided. A copy will be provided to you upon request. If you have any questions please feel free to contact our office. Thanks so much for being our patient.

Acknowledgment Form for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge the use or disclosure of my Protected Health Information (PHI) by AllerVie Health and its Subsidiaries and Partners for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of AllerVie Health. I understand that diagnosis or treatment of me by the healthcare providers of AllerVie Health may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. AllerVie Health is not required to agree to the restrictions that I may request. However, if AllerVie Health agrees to a restriction that I request, the restriction is binding on AllerVie Health and Healthcare Providers of AllerVie Health. I have the right to revoke this consent, in writing, at any time, except to the extent that Healthcare Providers of AllerVie Health or AllerVie Health has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices for AllerVie Health is provided in the patient reception area and I understand I have a right to review the Notice of Privacy Practices prior to signing this document. I also understand a personal copy of AllerVie Health's Notice of Privacy Practices can be provided to me for review upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of AllerVie Health.

AllerVie Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by reviewing the notices provided in patient reception area or by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Authorization and Consent for Treatment

The undersigned agrees, whether he or she signs as agent or as a patient, that in consideration of agreed upon services to be rendered, including allergy extracts and injections, by AllerVie Health to the patient, he or she hereby obligates himself or herself, assumes financial responsibility, and agrees to the AllerVie Health payment policy as outlined below regarding all charges for such services incurred by said patient. The undersigned consents to treatment as determined and discussed with and agrees to medication history review and reconciliation. The undersigned also specifically agrees that AllerVie Health can use PHI to communicate via phone, email or text for essential follow up needs, or appointment reminders, as well as conduct analysis for internal business purposes, customize patient needs for services and create de-indentified information to use and disclose in anyway permitted by law, including to third parties in connection with commercial and marketing efforts. This office will file and collect from insurance when insurance benefits are present. I hereby authorize AllerVie Health to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered to patient. I acknowledge that all information regarding my identity is correct and accurate to my knowledge. By signing/accepting this document I understand that I am held accountable for any false information which could result in a fine or penalty and should notify AllerVie Health if any of my information should change or if my identity is compromised or stolen.

Payment Policy

ALL DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE ARE DUE AT THE TIME OF SERVICE

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals: If you have an insurance plan with which we are contracted, you may need a referral authorization from your primary care physician/ pediatrician. ***If we have not received a referral at least 24 hours prior to your arrival at the office, your appointment may be rescheduled.***

Labs: All lab work is performed by an outside reference lab. AllerVie Health does not verify benefits coverage on lab services. Patients will receive a bill directly from the lab regarding any balances after insurance is filed. If you would like to check your lab benefits prior to these services being rendered, please inform the nurse.

Co-payments and Deductibles: All co-payments, deductible and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance: All patients must complete our patient information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment: We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Patient Statements: If you have an unpaid balance, you will receive a statement by mail or email monthly. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be will be turned over to an attorney or collection agency for collections. All payments made go to the oldest outstanding balance.

Self Pay: We accept self-pay for our services at select AllerVie locations. If you are uninsured or wish to self-pay for our services, we will also provide financial counseling for you at your appointment. Payment is due in full at the time of service.

No Show Fee: Should you need to cancel or reschedule your appointment, please contact our office 24 hours before your appointment to avoid any cancellation fees, up to $50.

By accepting the terms outlined above I understand that all bills are payable upon presentation, and that I, not the insurance company, is ultimately responsible for payment of the services.

Signature and Acceptance

I understand that selecting Agree and entering name/initials via portal, or signature below constitutes a legal signature confirming that I acknowledge and agree to the above policies set forth by AllerVie Health.

Patient or Legal Guardian/Responsible Party Signature	Printed Name	Date

Relation to Patient *(if applicable)*: _____