Patient Name_____ DOB_____

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, its Subsidiaries, and Partners for the purpose of diagnosing and providing treatment, obtaining payment, or conducting healthcare operations of AllerVie Health. I understand that diagnosis or treatment 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 AllerVie Health or Healthcare Providers of AllerVie Health have taken action in reliance on this consent prior to my withdrawal.

“Protected Health Information” means health information, including demographic information, collected, 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 past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may be able to be used to identify me.

The Notice of Privacy Practices for AllerVie Health has been provided via electronic access and can be provided in paper format, upon request. I understand I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur to ensure treatment, insurance collection, and performance of collaborative 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 online on AllerVie’s main website or by 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

Whether signing as an agent or as a patient, the undersigned agrees that in consideration of agreed upon services to be rendered by AllerVie Health to the patient, including allergy extracts and injections, the patient and representatives hereby obligates themselves, assuming financial responsibility, and agreeing to AllerVie Health’s payment policy as outlined below regarding all charges for such services incurred by the patient. The undersigned consents to treatment as determined and discussed with their AllerVie provider and agrees to provide accurate medical histories and participate in health assessment and treatment. The undersigned also specifically agrees that AllerVie Health can use PHI to communicate via phone, email, or text for essential follow up needs, appointment reminders, care coordination, as well as conduct analysis for internal business purposes, customize patient needs for services, and create de-identified information to use and disclose in any way 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.

Patient Name_____ DOB_____

Patient Financial Consent Policy

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

Thank you for choosing AllerVie Health. To ensure clarity about your financial responsibilities, please review & initial each policy:

Proof of Insurance: _____ *Initials*
- Provide updated insurance information and photo ID at every visit.
- Incorrect or expired insurance information may result in patient responsibility for charges.
- Inform us of insurance changes before your appointment.
- Unverified or denied insurance coverage will be your responsibility.

Insurance Coverage: _____ *Initials*
- AllerVie Health will file claims with participating insurers as a courtesy.
- You must pay copayments, deductibles, and coinsurance at the time of service.
- Understanding your insurance benefits is your responsibility.
- You must pay charges not covered by your insurance.

Copayments, Deductibles, and Coinsurance: _____ *Initials*
- Payment of copayments, deductibles, and coinsurance is required at each visit per your insurance agreement.
- Promptly provide additional information requested by your insurer.

Referrals: _____ *Initials*
- If your insurance plan requires a referral to see an allergist or a referral authorization number, you must ensure this referral is received by our office at least 24 hours prior to your appointment, or your appointment may be rescheduled.

Self-Pay: _____ *Initials*
- Self-pay patients must make payment at the time of service.

No-Show Appointments: _____ *Initials*
- Cancel appointments at least 24 hours in advance to avoid a $50 no-show fee.
- Appointments not canceled within this timeframe will incur a $50 fee, which will be charged directly to your account.

Failure to Pay: _____ *Initials*
- Past-due accounts may result in suspended non-urgent care, dismissal from the practice, or referral to collections.
- Unpaid debts may be reported to credit bureaus.

Card on File: _____ *Initials*
- We encourage patients to keep a credit card securely on file to facilitate payment.
- Card information will only be used for authorized healthcare-related charges.
- Authorization remains effective until revoked in writing.

Signature and Acceptance

I understand that payment for all charges is my responsibility, regardless of insurance coverage. By signing or electronically agreeing, I legally acknowledge and accept these terms.

_____ _____ _____

Patient or Legal Guardian/Responsible Party Signature | Printed Name | Date

Relation to Patient *(if applicable)*: _____