Insurance Liability Waiver

I, _____(Print Name), authorize Iowa Allergy, P.C. to release billing information which may include patient name, date and type of services, diagnoses codes, substance abuse treatment information and/or treatment plans to my insurance company for the purpose of: collecting insurance benefits and/or for authorization of additional service/sessions. I understand that my medical records may contain information regarding HIV/AIDS, Substance Abuse, mental health and/or other sensitive material that is received during the office visit. I also give permission that my insurance directly pays Iowa Allergy, P.C.

Although your insurance provider may cover all your fees, as set out in your insurance plan and Iowa Allergy, P.C. contracts with insurers, ultimately it is your responsibility to cover all your costs not covered by insurance. Some plans require preauthorization before your first visit. It is your responsibility to obtain this authorization. It is essential that you have researched your health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will be responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary (i.e., experimental or investigational and does not meet medical necessity criteria) or are of a quantity that exceed annual benefits, you will be responsible for full payment of your accrued fees.

Member to Initial:

_____Iowa Allergy has explained to you (prior to performing services) verbally and in writing that the services you are receiving may or may not be covered by your insurance benefits.

_____I have been given a benefit sheet with CPT codes, cost estimates, and verbally counseled on my benefits. This sheet and verbal counseling do not guarantee payment from insurance.

____You agree to bear full financial responsibility for all services that were performed by Iowa Allergy. The Explanation of Benefits (EOB) may show provider responsibility on these services, but they will be considered patient responsibility by the provider.

_____ _____

Patient/Parent Signature Date

8/20