Florida Allergy & Asthma Associates
5507 South Congress Avenue, Suite 140
Atlantis, FL 33462
561-965-6685 (P), 561-965-8525 (F)

For all Patients:

I hereby authorize Florida Allergy and Asthma Associates (FAAA) to furnish my insurance company or any representative thereof with any and all information which may be requested regarding my past or present physical condition and treatment. I hereby authorize FAAA to administer such medical care as may be deemed advisable in the diagnosis and treatment. I further authorize my insurance company or other parties to pay directly to FAAA, my medical expenses payable under the terms of my contract. In making this assignment I also agree that any balance not covered will be paid by me and that photocopies of this form will be valid. Should your account have to go to collections, you will be charged a fee of 30% of total charges.

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Signature of Patient of Person Authorized to consent for patient Date

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Name of Patient of Person Authorized to consent for patient

For all Medicare Patients:
PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Administration or its Intermediaries or Carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me

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Signature of Patient of Person Authorized to consent for patient Date

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Name of Patient of Person Authorized to consent for patient