Hanissian allergy
breathe better

a division of consolidated medical practices of memphis, pllc

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INSURANCE AUTHORIZATION AND ASSIGNMENT

PATIENT'S NAME: _____ Date of Birth: _____ Chart #: _____

All Professional services rendered through our facility are charged to you. As a courtesy to you, we will file all medical charges with your insurance company.

If your insurance requires a referral from your primary care physician, it is your responsibility to provide us with the required referral**. If** your insurance company does require a referral, please verify the number of visits allowed by and the expiration date of your referral. Please also verify that allergy shots or allergy vaccine vial preparation are covered by the referral.

I hereby authorize Hanissian Allergy (Consolidated Medical Practices of Memphis, PLLC) to provide information to insurance carriers concerning my care. I hereby assign to the physician or physicians all payments for medical services provided to me or my dependents.

With your help and cooperation you should receive all benefits available through our office and your insurance carrier.

My signature below indicates that I have read and understand the office policy stated above and agree to accept full responsibility as described.

_____DATE: _____

Patient or legally-authorized individual signature (parent, legal guardian, personal representative, etc.)

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)