



Allergy & Asthma  
s o l u t i o n s

## PAYMENT AUTHORIZATION

This Payment Authorization relates to a release of information, benefit assignment, payment authorization, full disclosure statement, and agreement to pay for professional services.

I \_\_\_\_\_, authorize Allergy & Asthma Solutions to release any information acquired during the course of my examination or treatment for the purposes of processing my insurance/medical claim. I agree to allow a photocopy of my signature to be used to process my insurance/medical claim for the period of a lifetime. I claim any insurance benefits due for services rendered by Allergy & Asthma Solutions and authorize and assign payment directly to Allergy & Asthma Solutions, regardless of my insurance benefits. I understand that I am financially responsible for any and all fees incurred, and I agree to pay such fees in full.

I have fully disclosed all information concerning the insurance/third-party benefits to which I am entitled. I understand that failure to disclose pre-certification/ second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by any care.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date