GEORGE R. GOTTLIEB, M.D., P.C.
ASTHMA AND DISEASES OF ALLERGY

PATIENT NAME _____ DOB_____

PHONE # _____ WORK # _____ CELL # _____

ADDRESS _____

INSURANCE POLICY

- It is **patient's responsibility** to be aware of their individual insurance coverage and what might be covered or non-covered services. Co-pay, co-insurance or deductible is expected at time of service in accordance with your insurance policy. If **referral** is required, **patient** is responsible for obtaining this from your **primary care physician** prior to visit.

- Although we will contact your insurance company concerning your coverage and co-pays, **we cannot guarantee your payment liability until claim has been finalized by your insurance company, according to your plan**.

- We must have your **most current** insurance card. This enables our office to file your insurance. If your card is not **current, you will be responsible** for payment of all charges before leaving the office.

In General, the HIPAA Privacy Rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of 'PHI' (Protected Health Information) be made by alternative means, such as sending information to the individual's office instead of their home.

I wish to be contacted in the following manner (CHECK all that apply):

HOME TELEPHONE NUMBER: _____
OKAY TO LEAVE MESSAGE WITH DETAILS _____, OR ONLY CALL BACK PHONE #_____. **OKAY TO SPEAK TO SPOUSE** _____ **OTHER** _____

WORK TELEPHONE NUMBER: _____
OKAY TO LEAVE MESSAGE WITH DETAILS _____, OR WITH ONLY CALL BACK PHONE #_____

WRITTEN COMMUNICATION: TO MY HOME _____, TO MY WORK _____ or FAX _____ FAX DESIGNATED #:_____

I GIVE THE ABOVE DOCTOR PERMISSION TO USE AND DISCLOSE 'PHI' NECESSARY TO CARRY OUT 'TPO' (TREATMENT PAYMENT OR OPERATIONS) THIS ALSO INDICATES A "GOOD FAITH EFFORT" WAS MADE ON BEHALF OF THE DOCTOR NAMED ABOVE.

BY SIGNING THIS FORM, I UNDERSTAND THAT THE PRIVACY PRACTICES OF THE OFFICE HAVE BEEN DISCLOSED TO ME. THIS INFORMATION WILL STAY ON RECORD FOR 6-YEARS.

I HAVE READ AND UNDERSTAND ABOVE INFORMATION

SIGNED: _____ **DATE:** _____