Antigen Kit Authorization

I, ___________________________,hereby give Denver Allergy and Asthma Associates, P.C. permission to assemble the antigen extracts prescribed for me by my physician. I understand that these extracts are mixed specifically for me and used exclusively by me each time I receive an allergy injection. Further, I understand there is a separate charge for the allergy extracts based upon the volume of extracts assembled for me. There will be an additional charge incurred for the administration of each injection.

The charge for my extracts will be up to a maximum of $_________. I understand that it is my responsibility to contact my insurance carrier to determine the extent of my benefits and the amount, if any, of my liability. I further understand that the portion of the extract charge which is considered to be patient liability must be paid within a maximum of five months from the date the extracts are mixed.

I certify that the billing information provided to Denver Allergy and Asthma Associates, P.C. is complete and accurate. I understand that the responsibility of prior authorization, precertification, and/or payment for medical services provided by this office is ultimately my responsibility regardless of insurance coverage.

I authorize Denver Allergy and Asthma Associates, P.C. to release all information requested or deemed necessary to secure payment of the amount(s) billed for the allergy extracts. I hereby assign directly to Denver Allergy and Asthma Associates, P.C. all medical, drug, and/or surgical benefits, if any, otherwise payable to me for the services rendered.

Patient/Legal Guardian Signature ____

Date ____

Patient's Name (Please Print) ____

Witness ____

DENVER ALLERGY
and Asthma Associates

Questions?
Call 303.234.1067
DenverAllergy.com

Fax 303.232.2967
info@denverallergy.com