Allergy & Asthma
Consultants of Mid-Michigan

**Ridhu C. Burton, M.D.**
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*Diplomates of the American Board of Allergy & Clinical Immunology*

**Patient Name**:_____ **Date**:_____

# ***Office Policies***

A copy of the ***NOTICE OF PRIVACY PRACTICES*** was made available to me:
(a copy of our NOTICE is available at our office(just ask) or online at www.lansingallergy.com

***Signature**:_____ **Date**:_____
Signature of Patient or Parent/Guardian

*STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS, INCLUDING MEDICARE, TO PROVIDER*

I request that payment of authorized insurance and/or Medicare benefits be made to Dr. Burton/Dr. Polasani for any services furnished to me by the physicians. I authorize any holder of medical or other information about me to release to my insurance carrier/healthcare financing administration and it's agents any information needed to determine these benefits or benefits payable for related services. ***I also understand that by signing this authorization I am financially responsible for any charges not covered by my insurance***.

***Signature**_____ **Date**:_____
Signature of Patient or Parent/Guardian

***Please be aware that our office does have the right to charge for the release of medical records, to complete FMLA forms, school forms and other miscellaneous forms. Payments are due before we complete forms or release any medical records.*** Please note your signature is not required for enforcement of such fee.

***Signature**_____ **Date**:_____
Signature of Patient or Parent/Guardian

If you do not show for a ***return visit appointment*** or give us at **least a 24 hour notice** when canceling a return visit appointment ***you will be charged a $50.00*** fee. ***New patient appointments will be charged a $100*** fee. Please note your signature is not required for enforcement of such fee.

Please be aware we sometimes do courtesy calls two business days prior to your scheduled appointment but ***please do not depend on these reminder calls as they are just a courtesy.***

***Signature**:_____ **Date**:_____
Signature of Patient or Parent/Guardian

Office use only:

☐ Patient refused to sign acknowledgment Employee Signature:_____

Initials:_____ Date:_____ Initials:_____ Date:_____ Initials:_____ Date:_____

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