Advanced Allergy & Asthma Family Care

Board Certified in Adult & Pediatric Allergy, Asthma, & Immunology

NEHA MADHOK, M.D. ***ARYE RUBINSTEIN, M.D.***

Acknowledgement of Receipt

I acknowledge that I have seen and been offered a copy of the notice of privacy practices of Advanced Allergy & Asthma Family Care PLLC.

I further acknowledge that I have had an opportunity to ask questions about this policy.

_____

(Signature)

_____

(Name of Patient)

_____

(Date)

If this acknowledgement is not signed by the patient, please print the information set forth below:

_____

(Name of person signing)

_____

(Relationship to patient)

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NEHA MADHOK, M.D. ***ARYE RUBINSTEIN, M.D.***

I _____ hereby assign all payments to be made directly to Advanced Allergy & Asthma Family Care, PLLC. I agree and acknowledge that information regarding my treatment can and will be submitted for billing purposes in written form and/or via electronic media to my insurance company or companies. I further authorize the release of information which the insurance carrier may request, (including but not limited to) copies of such records and/or reports derived from information in such records.

_____

(Patient signature)

_____

(Date)

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