Roger A. Harden, MD
Allergy and Immunology
11623 Angus Road, Suite 11
Austin, TX 78759
(512) 338-1366

Patient Name_____

Date of Birth_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices from the office of Roger A. Harden, MD.

_____
Printed name of patient

_____ _____
Signature of patient (or parent if minor)

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I authorize and request my insurance company to pay directly to Roger A. Harden, MD insurance benefits otherwise payable to me.
I understand that my insurance carrier, if applicable, may pay less than the actual bill for services.
I agree to be financially responsible for payment for all services rendered on my or my dependent's behalf.
I also understand that payment is due at the time services are rendered unless other arrangements have been made. I agree to pay any collection fees that are accrued if payment is not made.
I understand that returned checks are subject to additional collection fees.

I have read this information and understand it.

_____ _____
Printed name of patient

_____ _____
Signature of patient (or parent if minor) Date

RELEASE OF INFORMATION

I authorize the release of information, including diagnoses and records of examination and treatment of myself or of my child, to third party payors, to other healthcare providers, and, if indicated, to the person I have listed below.

_____ _____
Printed name of patient Name of other person to whom you want us to release information

_____ _____
Signature of patient (or parent if minor) Date