



Asthma Allergy Centre

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Adult and Pediatric Asthma and Allergy

Acknowledgement of Referral and Financial Responsibility

I _____ am aware that medical insurance is an agreement between the insurance company and myself.

Furthermore I understand that all co-pays are to be paid at the time services are rendered and my account balance is to be paid in full when I receive my monthly statement unless I have made other arrangements, **in writing**, with the billing department. I am aware that I am financially liable for any charges incurred which my insurance company does not cover. **I am also aware that any medical equipment that I purchase (Nasal Lavage or Polyp Kit for example) is to be paid for at the time that I receive it and that the Asthma Allergy Centre will not bill my insurance for these supplies.**

If my insurance requires a referral I am aware that I must obtain my own referral and that any services denied due to lack of a valid referral are my financial responsibility.

I have read and understand this form.

Responsible Party Signature

Date

**Asthma Allergy Centre
Tigard Office –**
Hwy 217 at Greenburg Rd.
9735 S.W. Shady Lane, Suite 102
Tigard, OR 97223
(503) 620-5614

**Asthma Allergy Centre
Aloha Office –**
1960 NW 167th Place, Suite 102
Aloha, OR 97006
(503) 645-8427

**Asthma Allergy Centre
Newberg Office –**
442 Villa Rd.
Newberg, OR 97132
(503) 538-7348

**Asthma Allergy Centre
McMinnville Office –**
435 NE Evans St., Suite 201
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(503) 434-9435