ALLERGY AND ASTHMA CENTER OF SOUTHWEST ARLINGTON

MOONHEE LEE, M.D.
DIPLOMATE
- **AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY**
- **AMERICAN BOARD OF INTERNAL MEDICINE**

PLEASE READ THIS CAREFULLY BEFORE SIGNING

Every effort is made to obtain detailed and accurate insurance benefit information on each individual patient that comes to our office. Unfortunately, the insurance companies do not guarantee that the coverage and benefit information they give is accurate and state this at the beginning of every call we make to them. Although rare, errors are occasionally made by them. We cannot be responsible for this and the balance of whatever the insurance company says you owe will be due from you. Additionally, you are responsible for telling us if your insurance has changed before you are seen or treated, because you may require a referral, a deductible, a waiting period on certain diagnoses and/or have a filing deadline on the new policy. You are responsible for payment if you do not inform us of new insurance prior to services. To avoid any misunderstandings regarding future account balances, we require you to sign this consent prior to rendering services to you if you want us to file your insurance for you. Thank you for your cooperation.

I am aware that the insurance benefits that were obtained on my or my family member's behalf are estimates of payments and are not guaranteed by the insurance company. I agree to pay the amount due stated on the insurance company payment explanation after it is processed by them, if it was not fully collected at the time of my visit.

_____ _____

Patient Name **(PLEASE PRINT)** Date

_____

Patient or Guardian **Signature**
(PLEASE SIGN YOUR SIGNATURE)