FLORIDA ALLERGY CLINICS
Specializing in Allergy & Asthma Care
for Children and Adults

1200 West State Road 434, Suite #112
Longwood, FL 32750
Office: 407-869-8747
Fax: 407-869-8108

Peter Ruggiero, M.D.

Insurance and Billing Information

Patient Name _____ Insurance Name _____

Address _____

City _____ State _____ Zip _____

Insurance Assignment and Release

I certify that I (and/or my dependent(s) have insurance coverage with _____

and assign directly to Dr. Peter Ruggiero, all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed one year from the date signed below.

Medicare/Medigap Authorization

Medicare # _____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made either to me or on behalf to: Dr. Peter Ruggiero for any services furnished to me by that provider, to the extent permitted by law. I authorize any holder of medical or other information about me to release to the Centers for Medicare, my Medigap Insurer and their agents any information needed to determine these benefits or benefit for related services.

Patient (please print) _____

Patient Signature _____

Date ____ / ____ / ____

Parent/Guardian (please print) _____