JOHN D. BRAY, MD
PEDIATRIC& ADULT ALLERGY/IMMUNOLOGY
PEDIATRIC PULMONARY DISEASE
SLEEP DISORDERS MEDICINE

FELLOW
THE AMERICAN ACADEMY OF ALLERGY
& IMMUNOLOGY
THE AMERICAN COLLEGE OF CHEST PHYSICIANS
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THE AMERICAN ACADEMY OF PEDIATRICS
THE AMERICAN SLEEP DISORDERS ASSOCIATION

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AMERICAN BOARD OF ALLERGY &
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AMERICAN BOARD OF PEDIATRICS
(GENERAL PEDIATRICS)
AMERICAN BOARD OF PEDIATRICS
(PEDIATRIC PULMONARY)
AMERICAN BOARD OF SLEEP
DISORDERS MEDICINE & CLINICAL
POLYSOMNOGRAPHY (ADULT&PEDIATRIC)

Instructions to Insurance companies from the Patient:

RELEASE OF INFORMATION: I hereby authorize the physician and/or supplier to release any information required to process this claim and claims for any future treatment unless rescinded by me in writing.

We cannot accept full responsibility for collecting your insurance claims or for negotiating a settlement dispute. We will also not become a party to any disputes between divorced or separated parents. BOTH PARENTS ARE AND WILL BE HELD RESPONSIBLE FOR THE CHARGES ASSOCIATED WITH SERVICE PROVIDED TO THE CHILD OR CHILDREN REGARDLESS OF CUSTODY ISSUES.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to John D. Bray MD for services performed. I also understand that any and all services (including allergy extract) that are not covered by the insurance will by my responsibility.

Date:_____Signature:_____

Notice of Privacy Practices

We are required to provide you with our "Notice of Privacy Practices". Please review this information.

Your Name (Patient)(please print)_____Date of Birth_____

I have been provided with a copy of the **"Notice of Privacy Practices".**

Signature (Patient or Parent/Legal Guardian) _____ Date _____

May we leave medical/appointment information on your "home" answering machine and/or Cell? Yes ____ No _____

Signature of Patient/Parent/Legal Guardian_____ Date_____

If you do not want any of your medical or financial information discussed with anyone please sign below.

Signature of Patient/Parent/Legal Guardian_____ Date _____

The above information is private and confidential and will be placed in your medical chart. The information on this form will remain valid until we are notified otherwise.