Allergy & Asthma Associates Financial Policy

We are committed to providing you with the best possible medical care while holding down medical costs. Your clear understanding of our financial policy is important to achieve this goal.

INSURANCE: It is ***YOUR RESPONSIBILITY*** to verify that your policy is in force on your date of service and to understand the insurance carrier's coverages, rules and regulations.
All co-pays, co-insurances, deductibles and charges not covered by your insurance are your responsibility and will be billed to you by our office.

CO-PAYS MUST BE PAID AT THE TIME OF YOUR VISIT

If you ***DO NOT have insurance****, we expect payment* ***IN FULL*** for all treatment at the time of service unless other arrangements have been made.

If your insurance requires a **REFERRAL**, ***it is YOUR RESPONSIBILITY to obtain the REFERRAL prior to the time of service.***

Our office accepts VISA, Mastercard, Discover, checks and cash. All payments are expected at the time of service. A $25.00 charge will be assessed to accounts whose check does not clear the bank.

COLLECTIONS: Patient accounts will be ***turned over to a COLLECTION AGENCY AFTER 90 DAYS*** *if the balance is not paid in full or payment arrangements have not been made with the Billing Department. You will be responsible for any fees charged by the Collection Agency. Accounts turned over to collections may result in dismissal from the practice.*

MISSED APPOINTMENTS*: Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.*

RELEASE OF INFORMATION: *I authorize Allergy & Asthma Associates to release any of my/mychild's information and/or records to all of my insurance companies to substantiate claims and payments.*

PLEASE READ AND KEEP THIS COPY

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ALLERGY & ASTHMA ASSOCIATES AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Signature of Patient/Guardian *Date:* ____________________