

PAYMENT POLICY



Patient Name _____ Date of Birth ____/____/____ Today's Date ____/____/____

PAYMENT TERMS:

1. Payment is due when services are rendered (unless you have a qualified insurance plan with whom A&A participates). All insurance co-payments are to be paid at time of service.
2. This office accepts payment by cash, check*, debit card, VISA, Master Card and Discover.
*A \$20.00 fee will be charged for any return check.
3. Personalized payment plans may be available for those without insurance. Patients without insurance will be required to pay 20% of fees on the Day of Service with balance arranged on Payment Plan with Billing or Patient Accounts.
4. Account patient balances over 60 days, without payment, will be charged a 1.5% finance charge per month. Accounts over 90 days, without payment, will be assessed collection fees and sent to a collection agency. Non-payment requiring litigation may also result in attorney fees being assessed. Payment Plans are available for unpaid balances.
5. Non-payment of your account could ultimately lead to dismissal from our practice, meaning we would no longer provide your healthcare.

HEALTH INSURANCE:

1. It is the patient's responsibility to provide this office with a copy of current insurance card(s), including identification number, policy or group number, claims mailing address, claims or customer service telephone number. If you change plans YOU MUST notify us IMMEDIATELY.
2. Our Billing Department will call to check insurance benefits, eligibility, and unpaid deductibles on all new patients and share this information with you. We cannot guarantee that the information we receive and pass on to you is absolutely correct, however, and we recommend that you verify the information with your insurance carrier yourself.
3. Referrals required by insurance plans are the patient's responsibility. If a patient arrives for an appointment without having received the necessary referral from their Primary Care physician, they may be asked to reschedule their appointment. If not, any and all visits / services received prior to receipt of the referral will be the patient's responsibility.
4. Claim denials by the insurance company are the patient's responsibility, unless the denial is for untimely claim filing due to no fault of the patient. (Claims will be filed within 30 days of date of service if A&A has been provided with correct insurance information.) Insurance exclusions and non-covered services are the responsibility of the patient.
5. Resubmissions of lost / unprocessed claims will be traced and re-filed one time by this office. We will make every reasonable effort to collect payment from your insurance company, but if the insurance does not pay your claim within 90 days of timely and correct filing, the patient / guardian will be responsible for the balance due. The patient is responsible for contacting their own insurance carrier to obtain payment, and this office is not responsible for any claim disputes with the insurance company. The patient is ultimately responsible for the total balance due in case of underpayment, non-payment, or out-of-network payment by their insurance.
6. Credit balances or overpayments will be reimbursed to the patient, - or if the patient prefers, credit balances can be applied to future services.

AUTHORIZATION:

I authorize this office to release any information pertinent to my case to my insurance company in order to facilitate claims processing and collect payments for services rendered. I also agree to have the insurance payment sent directly to Allergy & Asthma as provider of service.

I have read, understand, and agree to this payment policy document. (If patient is a minor, signature represents Parent or Legal Guardian.) IF PATIENT IS SELF, ONLY SIGNATURE AND DATE REQUIRED.

Signature: _____ Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

SSN: _____ DOB: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (H):# () _____ Cell #: () _____ Work #: () _____

Place of Employment: _____