Financial Policy

Partners in Allergy & Asthma Care, PA would like to welcome you to our practice. Our goal is to provide you with excellent medical care and to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any change in your name, address, phone number, or insurance.
- Your account is to be kept current—accordingly, all self-pay or insurance co-payments, co-insurances, and deductibles will be collected **at the time of service**, payable by cash, check, Visa, MasterCard, Discover, or American Express.
- If you do not have your payment(s), your appointment may be rescheduled.
- A **No Show Fee of $25** will be assessed to your account if you fail to notify us within 24 hours with your intent to cancel your office visit. **There will be a $50 fee assessed for missed testing appointments.**
- A returned check will result in a $25 service charge **AND** all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5.
- There is a $25 charge for the completion of medical forms (for example: disability, FMLA, etc.).
- **There will be a $25 charge for the completion of school forms, if not done at the time of a visit. Forms must be renewed each school year per the county school board. Our Providers take time to make sure the forms are completed correctly for your child. Our charge is for completion of the forms, not for the forms themselves. [Parents initial_______]**
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in the collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs, and attorney fees.

If you have health insurance coverage:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company***. Although we verify your benefits with your insurance policy, please be advised they only give us an estimate of your coverage. All insurance companies state that this is not a guarantee of payment.

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans. It is your responsibility to be aware of what service(s) being provided to you and if it is a covered benefit under your insurance policy. You are responsible for any non-covered charges not payable by your insurance policy.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact our Billing Coordinator promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **We are here to help you.**

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient Name (Please Print)	Patient Signature	Date
Responsible Party (Please Print) If other than patient	Responsible Party Signature	Date

Partners in Allergy & Asthma Care, PA
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