

## **ALLERGY & ASTHMA SPECIALTY CARE FINANCIAL POLICY**

Thank you for choosing our practice for your allergy and asthma care. Since your understanding of our Financial Policy is extremely important to us, we have outlined our policies below. If you have any questions regarding our financial policy please do not hesitate to call our office or ask at the time of your visit.

### **Payment Due at Time of Service**

Payment is due at the time services are rendered. It is important for you to understand that your charges such as co-pays, co-insurances, deductibles and services not covered by your insurance company are your responsibility. We accept Cash, Checks, MasterCard and Visa. There will be a fee for all returned checks. If the patient is a minor, the parent/guardian who brings the child in for a visit is the responsible party.

### **Insurance**

We have contracts with most of the major insurance carriers and as a courtesy to our patients will file the claims for you. However, the insurance policy is a contract between you and your insurance company so it is important that you understand its provisions. We cannot guarantee payment of your claim, as the insurance companies only quote us benefits; they never guarantee benefits.

If your insurance changes during the course of treatment with our office, you must notify us immediately. It is your responsibility to make sure that our office has the most current insurance information to avoid any delays or refilling of your claims.

If we are not contracted with your insurance company, you will be required to make the payment for services at the time of visit.

If you do not have insurance, payment for services rendered during the office visit will be due at the time of service unless prior arrangements have been made with our office.

### **Referrals**

If your insurance company requires a "Referral" for the visit from your Primary Care Physician, it is your responsibility to contact your primary care physician for the referral. It is not the responsibility of this office to contact them for you. If we do not receive a referral prior to your visit, you will be asked to reschedule your appointment until the referral can be obtained. Services rendered by our office without the required referral will serve as your consent for treatment(s) not covered by insurance and will be payable by you.

Please check the appropriate box(s):

- I have read and understand the above financial policy for Allergy and Asthma Specialty Care.
- I agree that the insurance I have provided to Allergy and Asthma Specialty Care is the most current insurance information.
- I do not have insurance and understand that payment in full is expected at the time of service.
- I agree to pay all charges that are my responsibility.

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Signature of Patient / Parent / Guardian

\_\_\_\_\_  
Date