FINANCIAL POLICY

As a private practice, we rely on timely payment from patients and insurers to provide community care. Please review, initial, and sign these policies prior to treatment.

_____ You must provide accurate insurance information and a copy of your card(s) at each visit. ***You are responsible for any charges resulting from failure to report or update your coverage***.

_____ You are responsible for confirming that our services are covered by your specific health plan. Please contact your insurer's patient service number with coverage questions.

_____ If your plan requires a primary care referral or prior authorization and you do not obtain it, you agree to pay all costs deemed not covered by your insurer.

_____ We will submit claims to your insurer and allow 90 days for a response. If the insurer does not respond within this timeframe, the balance will be billed to you. Please direct any non-payment disputes to your insurance carrier.

_____ If you are uninsured or we do not participate in your plan, full payment for services and any outstanding balances is required at the time of your visit.

_____ You agree to pay all ***co-payments***, ***co-insurance***, ***deductibles***, and ***delinquent balances*** at ***the time of service***. We accept cash, checks, and major credit cards (Visa, Mastercard, Discover).

_____ Patients must maintain an active credit card on file. You will be billed for all unpaid balances deemed your responsibility by your insurer unless other arrangements are approved by our billing department.

_____ I understand that any accounts that remain unpaid or delinquent will be referred to a collection agency, magistrate or attorney for further collection action in accordance with this office's guidelines. Additional fees beyond charges for medical services may incur.

I have read and agree with the financial policies stated above. I understand that Advanced Allergy & Asthma Centers may decline non-emergency treatment if my account is delinquent.

_____ _____

NAME OF PATIENT **DATE**

_____ _____

NAME OF GUARANTOR* **SIGNATURE OF PATIENT/ GUARANTOR**

_____

GUARANTOR'S RELATIONSHIP TO PATIENT

**A Guarantor is a person legally authorized to act for a minor, incapacitated, or dependent patient. By signing, you certify that you have the legal authority to consent to medical services and accept full financial responsibility for all services rendered.*