www.allergyinatlanta.com

THE ALLERGY & ASTHMA CENTER, LLC FINANCIAL POLICY

WE ARE PROUD TO BE A TEAM OF HEALTH CARE PROFESSIONALS WHOSE GOAL IS TO DELIVER THE FINEST AND MOST COMPREHENSIVE ALLERGY AND ASTHMA CARE AVAILABLE. IN THE INTEREST OF GOOD HEALTHCARE PRACTICES IT IS BEST TO ESTABLISH A POLICY TO AVOID MISUNDERSTANDINGS. FOR THAT REASON, WE HAVE ESTABLISHED THE FOLLOWING GUIDELINES:

PATIENTS WITH INSURANCE NEED TO REMEMBER THAT PROFESSIONAL SERVICES ARE RENDERED AND CHARGED TO THE PATIENT AND NOT THE INSURANCE COMPANY. THE ALLERGY & ASTHMA CENTER CONTRACTS WITH NUMEROUS INSURANCE CARRIERS AND IT IS NOT POSSIBLE FOR OUR STAFF TO KEEP TRACK OF INDIVIDUAL REQUIREMENTS OF ALL INSURANCE PLANS. BENEFITS VARY DEPENDING ON YOUR PLAN AND WHAT YOUR EMPLOYER HAS AGREED UPON WITH YOUR PARTICULAR INSURANCE COMPANY. IT IS THE PATIENT'S RESPONSIBILITY TO BE AWARE OF SPECIFIC GUIDELINES SET FORTH BY THEIR INSURANCE COMPANY.

PAYMENTS OF DEDUCTIBLES, COINSURANCES AND COPAYS ARE DUE AT THE TIME OF SERVICE AND WILL BE COLLECTED PRIOR TO BEING SEEN BY THE PROVIDER.

REFERRALS, PRECERTS AND PROVIDER SELECTION ARE ULTIMATELY THE RESPONSIBILITY OF THE INSURED. PLEASE KNOW AND UNDERSTAND YOUR HEALTH INSURANCE BENEFITS. IF WE ARE NOT INFORMED OF ANY SPECIAL REQUIREMENTS OF YOUR INSURANCE PROVIDER AND WE ORDER SERVICES THAT ARE NOT COVERED, WE WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY. IF WE PROVIDE SERVICES AND YOUR CONTRACT IS NOT IN EFFECT OR HAS A PRE-EXISTING CLAUSE THE CLAIM WILL PROBABLY BE DENIED AND WE WILL BILL THE PATIENT DIRECTLY. PLEASE REMEMBER IT IS THE RESPONSIBILITY OF THE INSURED TO KNOW THEIR INSURANCE PLAN.

IF YOU FAIL TO PROVIDE US WITH THE CORRECT INSURANCE INFORMATION AND A CLAIM IS DENIED INITIALLY BASED ON THE INFORMATION YOU PROVIDED, YOU WILL BE CHARGE A BILLING FEE OF $50 SO THAT THE CLAIM CAN BE REBILLED TO THE CORRECT INSURANCE COMPANY.

THERE WILL BE A CHARGE OF **$75 FOR APPOINTMENTS THAT ARE NOT CANCELLED WITHIN A 24 HOUR PERIOD PRIOR TO THE SCHEDULED APPOINTMENT. FUTURE APPOINTMENTS WILL NOT BE MADE UNTIL THIS FEE HAS BEEN PAID.**

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS NOTE.

I ALSO HAVE BEEN PRESENTED WITH A COPY OF THE ALLERGY & ASTHMA CENTER, LLC'S PRIVACY PRACTICES AND HAVE HAD ALL OF MY QUESTIONS AND CONCERNS ADDRESSED.

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PATIENT OR PARENT/GUARDIAN IF A MINOR DATE