ALLERGY & ASTHMA ASSOCIATES

FINANCIAL POLICY

We appreciate the confidence that you have expressed in selecting us as your physicians, and we are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. If you have any questions about our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

Payment in full is required at the time of service for:

1. Patients without insurance (self-pay)
2. Patients who are not covered by one of our contracted insurance plans.
3. Patients who do not provide us with contracted insurance information
4. Patients with outstanding balances owed for co-pays, and deductibles
5. Any non-covered services

ALL COPAYS ARE DUE AT THE TIME OF SERVICE

Co-Payment and Deductible
You are responsible for your deductible/coinsurance and co-payment. If you have questions or concerns regarding your out-of-pocket costs for any procedures or exams, please inquire of these costs from the Billing Department prior to these services being performed. The Billing Department will be happy to provide an estimate for the cost of services upon request at each visit for the costs that the patient will incur. Any statement of coverage/benefits from staff from any other department will not be considered valid. A lack of understanding on the part of the patient in what or how much their insurance covers or whether the tests/procedures are subject to their deductible does not waive their financial responsibility. ***The decision by the financially responsible party to refrain from inquiring with the Billing Department about the costs of services prior to them being performed is to be understood as meaning that the financially responsible party is satisfied with the out-of-pocket costs involved for said services should any be incurred.*** Your initials below indicate your acknowledgement and agreement to the above information.

_____Initials

We accept cash, personal checks, Visa & MasterCard
For Medicare & contracted insurance plans, we will bill all services at no charge as per the requirements of the insurance contract.

All returned checks may be subject to a $20.00 service charge. You may be responsible for other costs of collection as permitted by law.

If the patient is a minor (under 18 years of age and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined above.

It is your responsibility to obtain any required referrals for treatment at, or prior to, the time of service. Patients seen or treated in our office, without prior authorization from their HMO group, are responsible for the full charge of the visit. If you need to use a specific lab or x-ray facility, you must notify the nurse before the service is rendered.

Services rendered by this office that are not a covered benefit or extend past the allotted quantity for a given visit or procedure by your insurance policy will be the patient's financial responsibility.

Our office staff will assist you in working with your insurance carrier, but it is the patient's financial responsibility to contact their insurance company and understand their own insurance plans, the amount of covered benefits the insurance company provides and if needed, to ask for a quote of the estimated cost services ***prior*** to them being rendered.

I authorize my insurance benefits to be paid directly to Allergy & Asthma Associates.
I authorize Allergy & Asthma to release any medical or other information to my insurance company if requested.

"NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov. "
I understand that my signature below confirms that I have read, understand and agree to the policies described above.

_____
Signature & Date

Print Patient's Name_____

Revised 12/05/2018