

**OFFICE FINANCIAL POLICY FOR ALLERGY & ASTHMA CENTRE**

We have found that communication with our patients regarding our financial policy assists us in providing the best service to you. Please take the time to read the following and sign the bottom.

Our physicians and staff are committed to providing our patients with the best possible care. If you have insurance, we are eager to assist you so that you receive your maximum benefits. As a courtesy to you we will gladly file your insurance claims, as long as you provide us with all the necessary information. It is your responsibility to keep us up to date with your most current insurance carrier. This will assure we are always forwarding your claims to the correct carrier.

Payment is due at the time of service unless payment arrangements have been approved in advance. **COPAYMENTS ARE DUE AT THE TIME OF SERVICE. NO EXCEPTIONS PLEASE. WE ACCEPT PERSONAL CHECKS OR YOU MAY ELECT TO USE DEBIT CARDS, VISA OR MASTERCARD.**

**BASIC POLICY:** *Payment for service is due in full at the time services are rendered.*

**FOR PATIENTS WITH INSURANCE:** *We bill most insurance carriers for you if proper paperwork is provided to us. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 30 days of billing, professional fees are due and payable in full from you.*

**FOR PATIENTS WITH SECONDARY INSURANCE:** *We will bill your secondary insurance company as a courtesy to our patients. If the secondary insurance carrier does not pay within 30 days of billing, professional fees are due and payable in full from you.*

**NON-COVERED SERVICES:** *Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.*

**MISSED APPOINTMENTS:** *In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You may be charged **\$25.00** per missed appointment.*

**PLEASE CHECK ONE: I have paid my insurance deductible for the calendar year \_\_\_\_ YES \_\_\_\_ NO**

**INSURANCE PATIENTS: SIGNATURE ON FILE & ASSIGNMENT OF BENEFITS:**

*I request and assign to Allergy & Asthma Centre all insurance benefits otherwise payable to me for services rendered. I authorize the doctor to release all information necessary to secure the payment of benefits.*

*I understand my signature requests that payment be made to the provider of services, and authorize release of medical information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I have read, understood, and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.*

\_\_\_\_\_  
**PARENT/GUARDIAN NAME (please print)**

\_\_\_\_\_  
**PATIENT'S NAME**

\_\_\_\_\_  
**PARENT/GUARDIAN/PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**