



**BILLING/PAYMENT POLICY**

As part of our efforts to offer improved and convenient service to our patients, we have established a billing policy. Please spend some time to familiarize yourself with it.

Payment is due at the time of service, as per the following guidelines, by either check or credit card.

**WE DO NOT ACCEPT CASH.**

HMO/PPO Policies: We will follow the copay, co-insurance and deductible guidelines for your HMO/PPO policy. If your insurance policy is an HMO, which requires a referral, we must have either a written referral or a referral number before your visit or you will be responsible for payment in full at the time of service.

Indemnity Policies: We will file with your insurance company, less and deductible or co-insurance which will be payable at the time of service, for all services except for those related to follow up care/visits. Kindly note that we file with your insurance company as a courtesy to you. However each patient is ultimately responsible for the satisfactory payment of all fees incurred in relation to the services provided to him/her. Any outstanding balance 6 weeks after we have billed your insurance company is payable by you. We recommend that you follow up with your insurance company at regular intervals to avoid being billed.

Please note that any services which are not covered by your insurance policy are payable at the time of service.

We cannot coordinate benefits between multiple policies (Exception – Medicare recipient)

I have read and agree to the above billing policy: \_\_\_\_\_  
Patient/Guardian’s Signature Date

**AUTHORIZATIONS**

I authorize the Family Allergy & Asthma Consultants to release all or portions of its files regarding myself/the patient to other physicians who provide services for my/the patient’s care, to insurance companies for the purposes of processing claims, and to interested government agencies including Medicare and Medicaid.

We hereby irrevocably assign to the clinic all benefits to which the patient or I am entitled, including Medicare and Medicaid benefits, if applicable, and insurance proceeds. I authorize the clinic to act as agent for us and for the patient to collect insurance proceeds and we authorize the insurance carrier to pay all insurance benefits directly to the clinic.

\_\_\_\_\_  
Patient/Guardian’s Signature Date

**NON-COVERED SERVICES AGREEMENT**

Our staff will make every effort to assist you with your insurance company to ensure that your treatment is authorized and you receive maximum reimbursement to cover the cost of your treatment. In the event your company refuses to authorize your care as medically necessary, you will be responsible for all charges associated with your care.

If understand that if my insurance company refuses to authorize my care for any reason, that I will be responsible for all charges and payments for services rendered. Charges will reflect usual and customary rate for services.

\_\_\_\_\_  
Patient/Guardian’s Signature Date

**CANCELLATION POLICY**

If in the event you have to cancel or reschedule an appointment, we require 24-hour advance notice.

\_\_\_\_\_  
Patient/Guardian’s Signature Date

### MEDICAL FORM FEES

In the event that you need copies of your medical records, a letter from the doctor, or forms filled out, there is a fee for these additional services. The fees vary and we will notify you of the exact cost, depending upon your specific need. These services take up to 7 to 10 working days to complete due to high volume of requests.

\_\_\_\_\_  
Patient/Guardian's Signature

\_\_\_\_\_  
Date

### CONSENT TO TREAT A MINOR

I, \_\_\_\_\_ (Parent/Guardian) do hereby authorize Allergy, Asthma & Immunology to provide service to \_\_\_\_\_ (a minor under 18 years of age) with or without my presence.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

### PRESCRIPTION REFILL POLICY

Prescriptions will be refilled within 48 hours of request. We prefer that the pharmacy contact us with refill requests rather than the patient, as this helps expedite the process. PLEASE NOTE THAT REFILLS WILL NOT BE HANDLED AFTER HOURS.

\_\_\_\_\_  
Patient/Guardian's Signature

\_\_\_\_\_  
Date

### CONSENT TO BE PHOTOGRAPHED

Over the last 15 years we have found it most useful to have a photograph of the patient on the medical chart as an additional identification tool. The photograph helps differentiate persons with very similar names, those from the same family, those with suffixes, Jr. or Sr. or I, II, III, etc. They also help cut down on medical errors by preventing misidentification and help recall. **We highly recommend this additional identification tool.**

The sole purpose for which we would like to take your photograph is for identification purposes and it will be a part of your medical chart and as such will be treated with the same concern for privacy as your medical records.

To allow us to take your/your child's picture please sign here: \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian's Signature

\_\_\_\_\_  
Date