All Allergy, Asthma & Immunology Clinic, P.A.
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Financial Policy

Thank you for choosing *All Allergy, Asthma & Immunology Clinic!* We are committed to the success of your medical treatment and care. Please understand that payment of your bill is an essential part of this treatment and care.

For your convenience we have answered a number of commonly-asked questions about our financial policy. If you need further information, please ask to speak with a billing specialist or the office manager.

How may I pay?
We accept payment by cash, check, Visa or MasterCard.

Do I need a referral?
If you or your employer subscribes to an HMO plan with which we are contracted, you do need a referral from your primary care physician. You must have this PCP registered with your insurance company as your primary care physician; otherwise, they will not recognize the referral you have obtained. If we have not received authorization prior to your arrival at the office, we have a telephone available for you to call your PCP to request it. If you are unable to obtain the referral at that time, you will need to reschedule your appointment.

With which plans are you contracted?
We have contracts with most of the major insurance carriers. Since plans vary and change often, please give us complete information on your plan to assure contracted status.

What is my financial responsibility for services?
Your financial responsibility depends on a variety of factors. Some of these are explained below.

If you have...	You are responsible for...	Our staff will...
Commercial Insurance, also known as indemnity, "regular" insurance or "deductible, % coverage"...	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of the office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
An HMO or PPO with which we are contracted...	If the services you receive are covered by the plan, all applicable co-pays and deductibles are requested at the time of the visit.	Call your insurance company ahead of time to determine co-pays, deductibles and non-covered services for you. File an insurance claim on your behalf.
An HMO with which we are NOT contracted...	Payment in full for office visits, x-ray, injections and other charges at the time of the office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.

A point of service or out-of-network PPO...	Payment of the patient responsibility—deductible, co-pay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out-of-network benefits, co-pays, deductibles and non-covered services. File an insurance claim on your behalf.
Medicare...	If you have not met your $100 deductible, we ask that you pay it at the time of service, as well as the 20% coinsurance. Any services not covered by Medicare are requested at the time of the visit.	File the claim on your behalf. We will include any secondary coverage information on that claim so Medicare will forward the claim to your secondary carrier.
No insurance...	Payment in full at the time of the visit. We will give you a 15% discount for that payment in full.	Work with you to settle your account. Please ask to speak with a staff member if you need assistance.
Secondary insurance...		Provide any information you need to file your claim with your insurance company.

OFFICE/FINANCIAL POLICIES-Please read and initial each paragraph

_____I request that payment of Medicare and/or other insurance benefits be made on my behalf to All Allergy Asthma & Immunology (**AAAIC**) for any services furnished to me. I authorize any holder of medical information about me to release to **AAAIC** and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_____I appoint **AAAIC** to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____I understand that financial responsibility for medical services rests between me and my health plan. While **AAAIC** is pleased to be of service to file with my medical insurance for me, **AAAIC** is not responsible for any limitation in coverage that may be included in my plan. If my health plan denies a claim from **AAAIC** for any of these or other reasons, **AAAIC** cannot be responsible for the bill. It is my responsibility as the patient to pay the denied amounts in full.

PATIENT ACKNOWLEDGEMENT

I have completed all forms with accurate information. I have read and understand the above terms and payment obligations. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered by my insurance carrier.

_____ _____

Signature of Patient or Authorized Representative Date