**COMPREHENSIVE ALLERGY AND ASTHMA CARE PLLC**

# ***STATEMENT OF PATIENT'S FINANCIAL RESPONSIBILITY***

**Comprehensive Allergy and Asthma Care PLLC Welcomes you to our practice. We work hard to provide the highest quality care to you. Your clear understanding of our financial policy is very important to our professional relationship. Please remember that our contract for services is with you, and it is our policy that you are responsible for all fees regardless of insurance coverage.**

## Insurance Coverage

- It is **your** responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier.

- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility remains yours.

## Insurance Changes

- If **you** have had any changes in your insurance coverage- even if there is only a small change in the co-payment amount or a change in the expiration date of the policy-**you** must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

## Co-Payments, Co-Insurance and Deductibles

- Co-Insurance and co-payments are the **patient's responsibility.** Co-Payments are due at the time of visits.

- Deductibles are the **patient's responsibility**. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each patient's deductible is or how much has been met at the time of your visit.

- **You** will be responsible for a $25.00 service fee if the bank returns your check for non-payment.

## Commercial Insurances

- Because Comprehensive Allergy and Asthma Care PLLC does not participate with third party payment plans as an in-network provider we perceive your insurance coverage as a contract between the insurance company and you the patient or the patient's guarantor of fees.

## Medicare

- We participate and accept assignment with **Medicare B**. Any portion of the deductable that has not been met is your responsibility. Patients without a secondary insurance are responsible for the 20%.

## Self Pay

- Patient’s with out insurance coverage are expected to pay in full at the time of services

## Patient Balances

- Payment is due upon receipt of statement. Outstanding balances are due prior to the next appointment. (Unless prior arrangements have been made with our billing department). Balances not paid within the 28 days of the initial billing may be subject to a late fee or collections if more than 90 days in arrears.

## Laboratory Bills

- I understand the outside reference laboratory will bill me directly for all laboratory tests performed by Comprehensive Allergy and Asthma Care PLLC.

## Authorization For Assignment of Benefits and Release Of Information

I hereby authorize and direct payment of my medical benefits to Comprehensive Allergy and Asthma Care PLLC for any services furnished to me by the physicians. I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical services to third party payers and/or health practioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including fees for collection services needed. These policies may be changed or rescinded at any time

____________________________________ _________________________

Signature of Patient (or Responsible Party) Date

In-Lieu of digital signature

**Authorization Of Payments**

I hereby authorize payment directly to Comprehensive Allergy and Asthma Care PLLC and its physician(s) of medical benefits, otherwise payable to me for services provided. I understand that I am financially responsible for my health insurance deductibles, co-insurance and non-covered services. These policies may be changed or rescinded at any time

____________________________________ _________________________

Signature of Patient (or Responsible Party) Date

In-Lieu of digital signature

**Payment Options: Cash, Check, Visa or MasterCard**

I have read the above Patient Financial Responsibility Form and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I have read, understand, and agree to the above Financial Responsibility Form in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given accurate insurance information to the best of my knowledge for complete and timely payment. These policies may be changed or rescinded at any time.

____________________________________ _________________________

**Patient or Guarantor Name** Date

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Signature of Patient (or Responsible Party In-Lieu of digital signature

Printed Name________________________

I understand that my Health insurance carrier **may not pay** for certain charges generated for services provided by ***Comprehensive Allergy and Asthma Care PLLC*** The denial of payment may occur even if the provider believes certain services are medically necessary based on the prevailing standard of good medical care. I acknowledge that it will be my responsibility to pay for charges and cost incurred in total. These policies may be changed or rescinded at any time

***Completion Of Forms*** I understand that there will also be a charge of $25.00 for the filling out of life insurance, disability insurance and all other forms requiring the staff or physician. I understand that this charge is for each form or letter that Comprehensive Allergy and Asthma Care PLLC is requested to fill out.

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Patient Name Date

Employee Initital__________