

ALLERGY ASSOCIATES
FINANCIAL GUIDE

The following is information regarding our financial policies and procedures for your information and cooperation. Please do not hesitate to ask any questions. Participation relies on efficient utilization in order to contain costs. It is always a good idea to **check your insurance policy to verify your individual benefits.**

INSURANCE

We file insurance claims if we are participating providers of your plan and your insurance card is identifiable as a network in which we participate. Please bring your insurance card with you at the time of each appointment so we may make a photocopy. We cannot file insurance for you unless you provide a valid insurance card. Please note: *you are responsible for all charges to include but not limited to: your annual deductible, co-insurance, co-payment, non-covered service, pre-existing conditions, disputed claims and claims over 30 days.* If you feel a claim has not been paid correctly, or if discrepancies arise, please contact your insurance company directly for resolution, as we are unable to resolve certain issues for you. Payments are due at the time of service. If at any time your insurance changes, please notify us prior to any service. We do not file or accept Workers Compensation or Medicaid.

MEDICARE

Medicare assignment is accepted. **We do NOT participate in ALL Medicare alternative plans.** Patients are responsible for their annual deductible and paying the 20% co-insurance at the time of service. **We do not file secondary/supplemental insurance claims.** If you have a medigap policy, (claim is automatically forwarded to your secondary insurance from Medicare) please provide our office with this information. In the event that the medigap insurance does not pay within 60 days, you will be responsible for balance.

AUTHORIZATIONS

If your insurance company requires referral authorization for you to see us; pre-certification; or pre-treatment review authorization, please obtain this from your primary care physician **PRIOR to your visit.** Please understand that without authorization, (if required), services will not be covered by your insurance and your appointment will either need to be rescheduled or you will be responsible for payment in full. It is up to you to make sure the authorization has arrived prior to services.

SKIN TESTING/VACCINE/INJECTIONS

Allergy skin testing and injections are generally covered by insurance plans. **Please check your individual policy for coverage. Some insurance companies, including Medicare, have limits on the number of skin tests or doses of vaccine allowed in a certain time frame. PLEASE NOTE: WE CANNOT EXCEED THESE LIMITS.** It is important that, if allergy injections are started, they be continued on a regular basis according to the doctors scheduled protocol. Should your injections be spread out too long, dilutions may be required and these add to the number of dosages given in that time frame. You will be billed for dilution limits exceed.

MINOR PATIENTS

Minor patients must be accompanied by an adult for all treatments and visits. The adult accompanying a minor will be financially responsible at the time of service and should be the legal representative or guardian of the minor for the purpose of signing forms or authorizations that may be required as well as give permission to render procedures and/or treatment. A waiver is required if parent is unable to accompany minor for injections.

MISSED APPOINTMENTS

Because consultation time has been “reserved” for each visit, 24-hour notice is required in order to cancel an appointment. You may be charged for not showing up for your scheduled appointment or for excessive missed appointments. We cannot make additional appointments for patients who repeatedly fail to appear. **An uncancelled appointment is a discourtesy to the sick patient who is hoping to be seen that day.**

BILLING

Payment of your portion of fees by cash, check, Visa, Discover or Mastercard is due **AT THE TIME OF EACH VISIT. A re-billing fee may be added to account balances remaining after 30 days or for unpaid co-pays at the time of service.** A service charge is applied in the case of returned checks. If you anticipate any difficulty with payment, please contact our office in advance. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys’ fees, we incur in such collection efforts. There is a fee for medical records, unless sent to another physician’s for continuing care.

We thank you for your understanding and cooperation and look forward to assisting you with your allergic problems. Please do not hesitate to ask any questions regarding our policies, procedures or our fees.

Patient Name (Print)

Signature (Patient or Parent/Guardian)

Date