ALTOONA LUNG SPECIALISTS

PATIENT FINANCIAL RESPONSIBILITY POLICY

Your signature below forms a binding agreement between ALTOONA LUNG SPECIALISTS (Medical Provider) and the Patient who is receiving medical services or the Responsible Party for patients under the age of 18. The Responsible Party is the individual who is financially responsible for payment of all medical bills.

All charges for services rendered are due and payable at the time of service. We have contracts with most insurance companies, and we will bill them as a service to you. As the Responsible Party, you are responsible for insuring that we participate in your insurance and for all payments due if your insurance company declines to pay for any reason.

The parties and/or the Responsible Party:

- MUST, at each office visit, inform Altoona Lung Specialists of the current address and telephone number of both the patient and the Responsible Party;
- MUST present all current insurance cards at each office visit;
- MUST verify, at each visit, the name of your family physician and all other necessary demographics;
- MUST comply with the Altoona Lung Specialists Payment Policy, as follows:
  Effective immediately, we will require payment prior to any services being rendered, including any known co-pays, co-insurance(s), deductibles, and prior patient balances. We will require you to provide a credit card to secure payment for any unknown balance that your insurance carrier may not cover. Once Altoona Lung Specialists receives an Explanation of Benefits (EOB) from your insurance, and a statement is unpaid for thirty (30) days, we will charge your credit card for any outstanding balance that is owed. Your signature will be required for authorization of payment.
- MUST agree to pay a $45 fee for checks returned for insufficient funds.

Failure to show up for an appointment will require a $100 deposit before the appointment can be rescheduled. This deposit will be refunded once the rescheduled visit is completed. Failure to attend the visit will result in the forfeiture of the $100 deposit.

All account balances must be paid in full. Should collection proceedings become necessary to collect balances on overdue accounts, the Patient will be terminated from the Practice.

As the Patient or the Responsible Party, your signature indicates that you have read, understand, and accept the terms and conditions in the Patient Financial Responsibility Policy.

______________________	______________________
Patient Printed Name	Responsible Party Printed Name
______________________	______________________
Patient Signature	Responsible Party Signature
______________________	______________________
Date	Date