Patient Financial Responsibility Policy

Your signature below forms a binding agreement between ALTOONA LUNG SPECIALISTS and the patient who is receiving medical services, or guardian for patients under the age of 18. This individual 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 patient/guardian you are responsible for ensuring that we participate in your insurance and for all payments due if your insurance company declines to pay for any reason.

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. Your signature will be required for authorization of payment. The patient/guardian MUST agree to pay a $45 fee for checks returned for insufficient funds. **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.**

Medical Appointment Cancellation/No Show Policy

If you must cancel or reschedule your appointment, you must do so within 24 hours of your scheduled appointment. Failure to comply with this policy will result in a charge as outlined below:

- Any patient who fails to no show or cancels/reschedules an appointment and has not contacted our office with at least 24-hour notice will be considered a NO SHOW and charged a $20.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice a second time will be charged a $40.00 fee.
- If a third No Show or cancellation/reschedule without a 24-hour notice should occur, the patient may be dismissed from Altoona Lung Specialists
- The fee is charged to the patient, not the insurance company, and is due prior to the next scheduled appointment.

As a courtesy, the patient will receive a phone call (if we have the correct information on file) as a reminder prior to the patient's scheduled visit. Even if the patient does not receive this information, the policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager for consideration of waiving the no show fee.

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

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Patient/Guardian Printed Name Patient/Guardian Signature

_____

Date