FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

ALL PATIENTS MUST READ AND SIGN THIS AGREEMENT BEFORE THEY CAN BE TREATED BY ONE OF OUR PHYSICIANS.

APPOINTMENTS: If you cannot keep your appointment, you must give 24-hour notice so that we can offer another patient your time slot. If you are unable to provide us with this notice, you will be charged a **$50 no show/late cancellation fee.**

*Please verify, prior to appointment, your individual insurance benefits regarding copays, deductibles, or co-insurance.

REFERRALS: If your plan requires a referral from your primary care physician, it is your responsibility to obtain one prior to your appointment and bring a copy with you at the time of your visit. PLEASE NOTE: The PCP must submit the referral to your insurance carrier and it is your responsibility to contact the carrier to ensure the submitted referral was received. If you do not have a referral, you will be required to sign a financial waiver, which states that you will be responsible for that day's services, unless a referral is provided by the end of business day.

CO-PAYMENTS: By law, we must collect your designated co-payment. This payment is expected at the time of service. Please be prepared to pay your co-payment at each visit.

OUT-OF-NETWORK PLANS: You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plans charges. All patients will be responsible for their co-insurance and deductible. If we do not participate with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to Allergy Associates.

SELF-PAY PATIENTS: Payment is required at the time of service unless other financial agreements have been made prior to your visit.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS: The parent whom consents to the treatment of a minor child is responsible for payment of services rendered. Allergy Associates will not be involved with separation or divorce disputes.

ALLERGY INJECTION(S)/SERUM CONSENT/ TREATMENT: As courtesy, we will try to inquire about benefits for our patients. However, we do not guarantee any benefits nor do we guarantee payment by your insurance company. As a courtesy, we will assist you in filling out paperwork for any reimbursement from your insurance carrier, however we cannot guarantee payment from your insurance. You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will additionally be responsible for all charges we incur as a result.

WE ACCEPT CASH, CHECKS, AND MOST MAJOR CREDIT CARDS.

Thank you for taking the time to review our policies. Please feel free to ask questions or share with us specific concerns.

Patient's Name and/or Authorized Representative: _____

Relationship to Patient: _____

***Patient's Signature and/or Authorized Representative: _____**

Date Signed: ___/___/___