PATIENT RESPONSIBILITY POLICY for ADVANCED ALLERGY & ASTHMA FAMILY CARE

1. PATIENT'S FINANCIAL RESPONSIBILITY

- If I am uninsured or have a health insurance plan that we do not participate in as an " in- network" provider, I understand that I am responsible for paying all fees and expenses for the services rendered to me at the time of service.
- I understand that I am financially responsible for my health insurance deductible, coinsurance and non-covered services.
- Co-payments are due at time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- Patients may incur, and are responsible for payment of additional charges, if applicable, and may include:

-Charge for returned checks - $ 30.00
-Charge for cancelled visit without 24 hour notice- $25.00.
-School forms $5.00
-Medical Records – 0.75¢ per page.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Advanced Allergy & Asthma Family Care PLLC on my behalf for any services furnished to me by the providers.

3. REFERRALS

If my insurance plan has a designated primary care physician, I understand that I am required to obtain a written referral from that doctor. I must provide the office with the referral at the time of check-in. If I do not have a current, valid referral, I may be asked to either reschedule my appointment or pay for the visit at the time of service.

4. CANCELLATIONS

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will allow another patient who is waiting for an appointment to be scheduled. Cancellations made without 24 hours notice, do not allow for that appointment slot to be offered to another patient. Office appointments that are cancelled without at least 24 hours notice may be subject to a $25.00 cancellation fee. Patients who do not show for their appointment and who do not call within the 24 hours will also be subject to the $25.00 cancellation fee.

5. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize, Advanced Allergy & Asthma Family Care, PLLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

6. PRIVACY PRACTICES

I acknowledge that I have seen and been offered a copy of the notice of privacy practices of Advanced Allergy & Asthma Family Care PLLC. The notice explains how we keep your medical records private.

7. ASSIGNMENT OF PAYMENTS

I hereby assign all payments to be made directly to Advanced Allergy & Asthma Family Care. I agree that information regarding my treatment can be submitted for billing purposes in written & or via electronic media to my insurance company.

I have read the Patient Responsibility Policy and I agree to abide its term

____ ______________
Print name of Patient, Authorized Representative or Responsible Party **Date of birth**

____ ______________
Signature of Patient, Authorized Representative or Responsible Party **Date**