PATIENT RESPONSIBILITY POLICY for ADVANCED ALLERGY & ASTHMA FAMILY CARE/NJ ALLERGY & ASTHMA 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 bill
- 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
- If an outstanding balance goes to collections agency, I understand I am responsible for an additional 35% fee on top of my balance as well as any attorney fees incurred
- 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 or “no show”- $25.00, School forms $5.00 per form, Medical Records - 0.75¢ per page, credit card processing fee of 3%

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Advanced Allergy & Asthma Family Care PLLC/NJ Allergy & Asthma Care LLC 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 or electronic 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.

5. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize, Advanced Allergy & Asthma Family Care, PLLC/NJ Allergy & Asthma Care LLC 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/NJ Allergy & Asthma Care. 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/NJ Allergy & Asthma 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 by its terms.

_____

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

_____

Signature of Patient, Authorized Representative or Responsible Party Date