Allergy, Asthma Immunology Care

FINANCIAL POLICY

The doctor and staff at Allergy Asthma Arthritis Center of Central Florida would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address, telephone number or insurance changes.
- Your account is to be kept current - accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Services are payable by cash, check, Visa, MasterCard.
- If you do not have your payment(s), your appointment may .be rescheduled.
  • You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $25 service charge ***and*** all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5 and you will only receive a refund if the credit amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.
- There is a charge for the completion of paperwork (ex: disability, FMLA, etc.).
- There is a charge for copies of medical records $1.00 for the first 25 pages and $0.25 for every page after that. May take up to 30 days.
- Any unpaid balances older than 180 days may be subject to 1.5% interest per month.
- If an appointment is not cancelled or rescheduled 24 hours prior to the appointment time, there will be a charge of $50.00.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

If you have health insurance coverage:

We will submit your claims, however *we must emphasize that as medical providers, our relationship is with you, not your insurance company.* Although we attempt to verify your benefits with your insurance policy. Please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry and not a guarantee of payment to our office.

By signing below you confirm that you understand:

- **It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment. If we send your claim to the wrong insurance policy and they denied payment then you will be fully responsible for those charges.**
- **If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.**
- **Not all services are a covered benefit with all insurance plans.**
- **It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.**
- **Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.**

I have read, received a copy and understand the above Financial Policy and agree to meet all financial obligations.

Patient Name (please print)	Patient Signature	Date
Responsible Party (please print) (If other than patient)	Responsible Party Signature	Date

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