Asthma & Allergy CENTER

Roanoke
1505 Franklin Rd SW
Roanoke, VA 24016
(P) (540) 343-7331
(F) (540) 343-7349

Lynchburg
2015 Tate Springs Rd.
Lynchburg, VA 24501
(P) (434) 846-2244
(F) (434) 846-0602

Salem
3529 Keagy Rd
Salem, VA 24153
(P) (540) 343-7331
(F) (540) 725-1356

Patient Financial Policy

Thank you for choosing Allergy & Immunology, PLC (the Asthma and Allergy Center) as part of your healthcare team. We are committed to building a successful physician-patient relationship with you and your family. Your understanding of our financial policy is an important piece in building that relationship. Please ask our staff If you have any questions about our policies or about your responsibilities.

We require that all patients complete the Patient Financial Policy prior to seeing the provider. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

1. **PAYMENT** is due at the time of service unless other financial arrangements have been made in advance. We require all patients to pay their copay and/or coinsurance payment at the beginning of each visit. After the conclusion of each visit, the patient will be billed for any remaining balance, including, but not limited to the patient's deductible and any uncovered services as contractually allowed. The patient, or responsible party if patient is a minor, is ultimately responsible for payment for any professional services rendered, regardless of insurance.

   By signing this form, you are acknowledging that you understand and authorize that, when requested by you, Allergy & Immunology, PLC will send emailed receipts of payment. These receipts will be transmitted over an unsecure channel and there is a chance they may be intercepted by a 3rd party.

2. **INSURANCE** It is the responsibility of the patient to provide our office with current insurance information and to complete any forms necessary to expedite payment by the insurance provider. The patient is expected to present an insurance card at each visit. A quote of benefits provided by Allergy & Immunology, PLC is not a guarantee of benefits or payment. Insurance coverage is verified as a courtesy and does not guarantee payment. Not all insurance plans cover all services.

   Your insurance policy constitutes a contract between you and the insurance provider. Some insurance plans require precertification or a referral from a primary care physician to cover our services. It is the responsibility of the patient to obtain any precertification or referrals necessary for payment. The patient, or responsible party if the patient is a minor, is ultimately responsible for all charges. Please check with your insurance carrier to verify coverage.

   It is the policy of Allergy & Immunology, PLC to file insurance claims with a primary carrier and one additional secondary carrier. Any additional claims will have to be submitted by the policy holder.

   By signing below, you also request that all payments of authorized Insurance Company benefits

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be made either to you or on your behalf to Allergy & Immunology, PLC for any services furnished to the patient by this office. Regulations pertaining to Medicare assignment of benefits apply.

3. **RETURNED CHECKS** will incur a $50 service charge payable by cash, credit, or money order. This amount will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash or credit only basis following any returned check.

4. **OUTSTANDING BALANCE** It is the policy of Allergy & Immunology, PLC that all past due accounts will be sent two statements. If payment is not made on the account, a single phone call will be made to attempt to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney.

   In the event an account is turned over for collections, the individual financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs. By signing this form, you are acknowledging and authorizing the Collection Agency to contact you via phone (including cellphone), text message, or email with an automated message when applicable. You are acknowledging that you will be responsible for any additional fees issued by your wireless carrier as a result of these calls or messages. You are also acknowledging that you may be required to pay upfront for all services rendered.

5. **MEDICAL RECORDS** requests are processed in timely manner, in accordance with both federal and state law. Patients requesting copies of their medical records will be assessed a charge of $0.25 per page with a $5 minimum charge.

6. **CANCELLATIONS and MISSED APPOINTMENTS** Allergy & Immunology, PLC strives to provide prompt and timely care to all patients. No-Shows or late cancellations prevent other patients from receiving care. Allergy & Immunology, PLC requires 48 hours notice to reschedule appointments. Appointments rescheduled without this notice period may incur a $25 charge. Missed appointments may be charged a $60 fee. These charges are the responsibility of the patient and are not covered by insurance.

7. **MINORS** If a patient is a minor, the parent or guardian who authorizes treatment will be held financially responsible for all professional services provided to the patient by Allergy & Immunology, PLC. If a court order is in force that outlines other arrangements, it must be provided promptly to Allergy & Immunology, PLC.

I, the undersigned, acknowledge that I have read the statements above and agree to the terms and conditions. I accept responsibility for payment of all professional services provided to the patient by Allergy & Immunology, PLC.

Patient Name:_____ DOB:_____

Guardian (if applicable): _____ Relationship:_____

Signature:_____ Date:_____