Financial policy of Asthma & Allergy Associates, P.C. (The Practice)

The following is the financial policy of the practice which is required of all patients and/or guardians of patients to read and sign prior to treatment. Your portion of the payment is due at time of service. We expect payment in full for any copays, deductibles, co insurance and/or cost share deemed your responsibility by your insurance.

1. **Credit Card on File**. If you have a copay, deductible, co insurance and/or cost share per your insurance plan, you will be required to issue to the practice a credit card to place on file to pay for your balance due after insurance has processed. Your credit card information will be securely tokenized (digitally altered for security purposes) within the electronic health records system. Please be prepared to pay towards your deductible and/or patient responsibility at time of service and to supply a credit card account number for future balances. The practice will charge your credit card any balances due after insurance has processed your claims and a statement and receipt will be mailed to you. By signing the financial agreement below, you are authorizing the practice to charge your credit card for balances due.
   a. If you prefer to not place a credit card on file and wish to pay with cash or check, payment in full at time of service will be expected. Please call us before your appointment/antigen order to obtain an estimate at 719-473-1800 option 5. The amount that you will be quoted is an estimate and may not be the correct amount owed in which case you will receive a statement for further payment or a refund for overpayment.
2. **Payment Plans**. Payment plans are not offered by the practice.
3. **Delinquent accounts** over 90 days will be written off by the practice as bad debt and sent to a third party collection agency.
4. **Returned checks** will be charged a $35 insufficient funds charge in addition to the original amount due.
5. **Patient Refunds** will only be issued in the case of incorrect billing or receipt of over payment.

The practice will file insurance claims with most standard carriers including Indemnity, HMO, PPO and Government issued insurance. It is the patient's responsibility to ensure that the practice has accurate insurance information including prior authorizations if needed. If, for any reason, your insurance claims are denied or unpaid, the patient becomes solely responsible for payment of the services. By this agreement, the patient authorizes the exchange of information relating to care and claims to and from the patient's health insurance carrier as well as the practice's billing staff. The patient authorizes payment from their insurance company to be made directly to the practice.

I certify with my signature below, that I authorize medical treatment of the person named below and I agree to the financial agreement as outlined above. I authorize payment of my insurance benefits to be made directly to Asthma & Allergy Associates for any service rendered by a physician or practitioner employed by the practice. I authorize the release of medical information needed to complete insurance claims, to communicate with my primary and/or referring doctor's office, and to coordinate care with outside physicians, laboratories, pharmacies or facilities. I authorize the practice to charge my credit card on file for balances owed by me as the responsible party.

Patient Agreement: I have read and understand the Financial Policy above and agree to the terms.

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Signature (Patient/Guardian if under 18) Printed Name (Patient/Guardian if under 18)

Date: _________________________________ Social Security Number __________-__________-_____________