Family Allergy &
Asthma Center, P.C.

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FINANCIAL POLICY

Welcome to Family Allergy & Asthma Center, P.C. We want your experience with us to be a pleasant one. With all of the changes in healthcare, we know it can sometimes be frustrating to keep up with all of the restrictions and requirements associated with your healthcare plans. We hope the following information will help clarify a few of these issues for you:

It is in your best interest to know **exactly** what services are provided by your specific insurance plan. We care for patients who are covered by many different insurance companies and **each plan** may **differ** in services covered.

If you are going to have a procedure (e.g. skin testing) done in our office, we strongly recommend that you contact your insurance company and verify your benefits **prior** to the procedure.

If it is necessary to refer you to another physician you will want to verify with them that they are indeed providers under your plan. As a sub-specialist, we are not authorized to make referrals if required by your insurance plan. These must be obtained from your **primary care physician**.

If your plan requires an office co-pay or deductible, payment is required at the time of your visit. If your deductible has been met, please provide our office with written documentation. The remainder of your covered services will be submitted by our office to your insurance company. Please sign the "assignment of benefits" below to allow us to file your insurance claims. **You will be responsible for any non-covered services,** for which payment is to be made at the time of your visit. In the event of a financial hardship, a 30-day payment plan is available. Please speak with our office manager to make such arrangements.

If your insurance coverage changes to a network with which we are not associated, you may wish to determine if you have **"out of network"** benefits. This will allow you to continue to receive your care from us with altered financial coverage.

Please present your insurance card to our receptionist at each visit. Please do not forget to notify us of changes involving insurance, name, or address.

We want to thank you for choosing Family Allergy & Asthma Center, P.C. for your healthcare services. If you have any questions or concerns, do not hesitate to speak with our staff. We will be happy to assist you.

I hereby authorize Family Allergy & Asthma Center, P.C. to release to my insurance company information acquired in the course of my examination or treatment. I hereby authorize benefits to be paid directly to Family Allergy & Asthma Center, P.C.

I understand I am responsible for any charges incurred that are not paid by the insurance company to Family Allergy & Asthma Center, P.C.

I also understand I am responsible for all charges incurred from outside consultation services such as radiology, laboratory, and referral to another physician, etc., and it is my responsibility to submit or request submission of other services to my insurance company.

______________________________ Signature of Patient/Guardian

______________________________ Date