Allergy Asthma & Immunology Institute

19455 Deerfield Ave. Suite 205

Lansdowne VA 20176

Importance of Patient Awareness Regarding Insurance Benefits:

Allergy Asthma & Immunology Institute realizes how important insurance benefits are. **We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of your benefits, deductibles, frequencies, and restrictions**. Please be informed that insurance is a contract between you and your insurance company. Our role is to assist you with filing your claims. Allergy Asthma & Immunology Institute is providing the highest quality of care for you and your family regardless of insurance benefits and deductibles. Please be aware that your insurance may have a yearly deductible. You will be responsible for payment of half of the allowable balance of your remaining deductible during your first visit. Your responsibility also extends to include the copay for specialists services, if applicable. Your insurance mails a copy of the Explanation of Benefits (EOBs) to you. Please pay attention to these statements. Please provide us with a copy of your insurance card(s) at the time of your first visit or at the time of insurance coverage changes. **It is your responsibility to provide us with any future changes in your insurance as soon as possible.**

Please sign below, indicating that you have contacted your insurance company and have checked your plan allergy benefits **_____ (Signature)**

FINANCIAL POLICY

In order to provide you with the highest quality medical care on a sound business basis, we will provide an estimate of fees to you, if requested. Patient, parent and/or guardian are responsible for the patient portion. This is not your insurance company's responsibility. **We will file all necessary claims to your insurance as a courtesy to you**. It is your responsibility to contact your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and interest will be applied to your account at the rate of 1.5% of the unpaid balance per month.

ASSIGNMENT OF INSURANCE BENEFITS:

Patients with insurances please read and sign below:

I hereby assign all medical benefits related to services from Allergy Asthma & Immunology Institute, to include medical benefits to which I am entitled, private insurance, and any other health plans, to Allergy Asthma & Immunology Institute. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary in order to secure payment.

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____

(Continued on reverse)

MEDICARE PATIENTS:

I request payment of authorized Medicare benefits be made on my behalf to Allergy Asthma & Immunology Institute, for any services furnished to me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on the other approved claims or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the ***deductibles*** *are based upon the charge determination of the Medicare carrier.*

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____

FINANCIAL OPTIONS

Check those that apply:

1. ____ Cash or check on date of service
2. ____ Major Credit Card – MasterCard and Visa preferred. American Express and Discovery also accepted.
3. ____ Extended payment plan – Based on credit approval for a maximum of 6 months for larger balances only.

It is your responsibility to complete recommended follow-up appointments as directed by Allergy Asthma & Immunology Institute. If follow-up appointments are missed, adverse results could affect your health.

I have read and understand the above information **_____ (Initials)**

APPOINTMENT COMMITMENT

We appreciate you choosing us to meet your medical needs. We take this responsibility seriously and have qualified team members to accommodate you during your reserved appointment time. If circumstances occur and it is necessary to change your scheduled appointment, we request that you give us at least a 24 hour notice. A broken appointment, one in which a patient does not call or show up, is unacceptable. If you have scheduled an appointment and do not show up or call, it may be necessary for you to come into the office personally and schedule any future appointments. There may be a $45.00 fee assessed for the missed appointment.

I have read and understand the above information **_____ (Initials)**

I understand and agree to the aforementioned, and I agree to pay any/all remaining balance on my account.

Signature: _____ Date: _____

I ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF ALLERGY ASTHMA & IMMUNOLOGY INSTITUTE'S NOTICE OF PRIVACY PRACTICES.

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If insurance doesn't pay for **D.** services below, you may have to pay. insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect insurance may not pay for the **D.** services below.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
94060 PULMONARY FUNCTION TEST		$75-$125

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** services listed above. You may ask to be paid now, but I also want insurance billed for an official decision on payment, which is sent to me on a Insurance Summary Notice. I understand that if insurance doesn't pay, I am responsible for payment, but **I can appeal to insurance** by following the directions on the EOB. If insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** services listed above, but do not bill insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if insurance is not billed.**

☐ **OPTION 3.** I don't want the **D.** services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, call the customer service number on the back of your card. Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

A. Notifier:

B. Patient Name: **C. Identification Number:**

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D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
95044 Patch Testing		$200-$400

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D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
95004- Allergy Skin Testing		$300-$600 per allergy test

WHAT YOU NEED TO DO NOW:

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