

# 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.**

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

## 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: \_\_\_\_\_

**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: \_\_\_\_\_