Allergy and Asthma
Clinical Centers

Manassas, VA: 8100 Ashton Avenue, Suite 207 B, Manassas, VA 20109 . 571.208.0186
Germantown, MD: 19735 Germantown Rd., Suite 255, Germantown, MD 20874 . 301.444.5578
Poolesville, MD: 19710 Fisher Avenue, Suite J, Poolesville, MD 20837 . 301.591.9699
Toll Free: 1855.5CURE4U (528.7348) . **Fax:** 855.FAX.CURE (329.2873)
Web: www.allergycurecenters.com

ALLERGY AND ASTHMA CLINICAL CENTERS – FINANCIAL, PAYMENT AND GENERAL OFFICE POLICIES

Please read and review carefully

Patient name:_____Date:_____

CONSENT FOR TREATMENT

The undersigned hereby agrees and consents to the administration of such medical treatment, diagnostic and/or therapeutic medical and surgical procedures for themselves and/or their children as deemed necessary by the Allergy and Asthma Clinical Centers' (further AACC) physician rendering the care. The procedures may include, but are not limited to, surgery, laboratory and radiodiagnostic procedures.

RELEASE OF MEDICAL INFORMATION/SIGNATURE ON FILE/AUTHORIZATION

I authorize AACC to release medical information as necessary to process insurance claims, insurance applications, and prescriptions. I hereby authorize AACC to apply for insurance benefits on my behalf for covered services rendered and I authorize the payments from my insurance company to be made to AACC. I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.
PHONE CALLS: AACC's physicians or staff may need to leave medical information regarding your care on your answering machine if you are not available. Should you have any restrictions to this policy please inform our staff prior or at the time of your appointment.

DEEMED CONSENT (HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION)

In accordance with state and federal laws, any patient to whose body fluids a healthcare worker has been exposed will be deemed to have consented to HIV/ Hepatitis B & C testing. In all other cases, the patient shall have the right to informed consent or refusal of HIV/Hepatitis B & C testing.

FINANCIAL POLICIES

REFERRALS AND AUTHORIZATIONS: Should your insurance company require a specialist referral from your primary care physician before you can be seen by our specialists, it is your responsibility to obtain such referral prior to your appointment. Please forward it to us prior to your appointment or bring it with you. We are prohibited from seeing you and billing your insurance without a referral. If you are seen without a referral, you will be required to pay for all services rendered. If you are unsure how to obtain the referral, please let the AACC staff know and we will be happy to provide assistance.

INSURANCE COVERAGE AND PAYMENTS: You, the undersigned, are responsible for paying at the time of service your deductible, co-insurance, and co-payment associated with your in-network or out-of-network insurance plan. The parent/guardian of a minor who brings him/her in for treatment is responsible for the co-payment, co-insurance and/or deductible for that patient. Allergy and Asthma Clinical Centers accepts cash, personal checks, and certain credit/debit cards. If your check is declined, you will be responsible for a $50.00 returned check fee in addition to the original service fees and you may be required to make all subsequent payments in the form of cash, credit card, or money order. You also understand that you may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratories, as appropriate and in accordance with the services rendered.

If we participate (contract) with an insurance plan under which you are covered, we will bill the carrier directly for charges for the rendered services except co-pays, co-insurance and deductibles. We will bill both your primary and secondary insurance plans for contracted plans. However, in the event that the secondary does not pay within 60

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days, you will be billed for the balance.

If we do not participate and are out-of-network with an insurance plan under which you are covered, it is your responsibility to verify your policy includes out-of-network benefits before your first visit. As a courtesy, we make a reasonable effort to submit your claims to your carrier. You will be responsible for all balances on claim denials if there are no out-of-network benefits available.

It is your responsibility to inform us of any special requirements in your insurance contract, such as referrals, pre-authorizations or non-coverage for specific diagnostic and/or treatment services. In the event we are not aware that a particular service is not covered by your plan, you will be responsible for the balance after we obtain a denial from your insurance carrier. Please remember that any denial of a claim is between the policyholder/subscriber and their insurance and you as the patient or guarantor are responsible for the payment for rendered services.

After we receive payment (or denial) from your insurance plan and if there is a balance due, we will mail a detailed billing statement to the home/mailing address you provided to our office. The statement will be mailed on or around the first of every month until the balance has been satisfied. You are responsible to pay your balance within 30 days of the statement date. **Patients with an outstanding balance overdue by 60 days or more must make arrangements for payment prior to scheduling future appointments. If you have any questions regarding your bill, please call our billing department for assistance at (703) 249-8500. However, you understand that disputes or denials concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company and you, the patient or guarantor, are responsible for payment on your account.**

We reserve the right to forward your account to a collection agency/attorney for non-payment if it is 60 or more days overdue. If the account is sent to a collection agency or a collection attorney, a 34 % collection charge will be added to the unpaid balance. In addition to the amount owed, you will be responsible for the collection charge and any additional fees/costs permitted by law associated with the collection. You understand that the collection will have an impact on your credit rating.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Cancelled appointments deprive other patients of opportunity to be timely seen and negatively impact patient care and waste resources of our practice. Thus, appointment cancellations and/or rescheduling are to be requested at a minimum of 24 hours prior to the appointment. If you do not show for your appointment or cancel with less than 24 hours' notice, a fee of $50 will be charged to your account. Abuse of scheduled appointments may result in discharge from the practice.

MISCELLANEOUS EXPENSES:

Copy of medical records - You agree to pay cost of having medical records copied which are .50 per page for the first 50 pages and .25 per page thereafter in addition to a $10.00 regular postage/handling fee.

Reports/documents preparation – you agree to pay administrative fee of $30 for AACC physician's review of records and preparation of progress, summary or discharge reports, notes or statements.

School forms – School forms and similar documents are to be requested and will be completed only during a scheduled appointment. If you require a completion of a school form outside of yours or your child's regular appointment, processing fee of $10 will be charged for a completion within 3 business days per form or $20 per form if same day completion is requested.

CERTIFICATION

I certify that the information I have provided to AACC regarding applicable insurance coverage is correct and current and **that I have read and understand the forgoing. As the patient/guardian/guarantor I understand and fully accept the terms and policies as well as the charges incurred as detailed above.**

Patient or Responsible Party Signature:_____ Date:_____

Printed Name: _____ Relationship to Patient: _____