Premier Allergy and Asthma Centers

PREMIER ALLERGY AND ASTHMA CENTERS – FINANCIAL AND GENERAL OFFICE POLICIES

Please read and review carefully

CONSENT FOR TREATMENT

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

RELEASE OF MEDICAL INFORMATION/SIGNATURE ON FILE/AUTHORIZATION

I authorize AACC to release my or my dependent's medical information as necessary to process insurance claims, prior authorizations, and prescriptions. I hereby authorize PAAC to file insurance claims on my behalf for the services rendered and I authorize the insurance payments to be made to PAAC. 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.

PHONECALLS:PAAC staff may need to leave medical information regarding your care on your answering machine if you are not available. Should you have any restrictions on this policy please inform our staff prior or at the time of your appointment.

FINANCIAL POLICIES

REFERRALS AND AUTHORIZATIONS:

It is your responsibility to obtain a referral from your primary care physician prior to your appointment with our specialist if it is required by your insurance. Please ask your primary care provider to file the referral authorization electronically or by fax directly with your insurance. Please forward us a copy prior to your appointment or bring it with you. Your **insurance will deny a claim without referral**. If you are seen without a referral, you will be obligated to pay for all the services rendered. **We will not be able to re-submit your claim if you obtain the referral only after you have been seen**. If you are unsure how to obtain the referral, please let the PAAC staff know, and we will be happy to help.

INSURANCE COVERAGE:

You, the undersigned, are responsible for paying at the time of service your co-pay for the services rendered to you or your minor. **If you request or consent to proposed allergy testing and your unmet deductible exceeds $350, you will be required to pay $350 prior to the testing.**

If we participate (contract) with your insurance plan, we will bill the carrier directly for charges for the services rendered. You are responsible for all co-pays, co-insurance and deductibles. We will bill both your primary and secondary insurer for contracted plans. However, if the secondary does not pay within 60 days, you will be billed for the balance.

If **we do not participate** and are out-of-network with your insurance plan, it is **your responsibility to verify that your policy includes out-of-network benefits before your visit**. **You will be responsible for all the claims balances including claim denials due to limited or no out-of-network benefits available in your policy**

It is your responsibility to be aware and inform us if your insurance coverage has limits for specific diagnostic services, such as number of allergens allowed for your testing. If you request

and receive services exceeding the limits or not covered by your plan you will be responsible for payment for those services.

CREDIT CARD AUTHORIZATION, PAYMENT AND STATEMENTS:

You will be required, at the time of service, to provide credit card information to be kept securely on file. Once your insurance claim is processed by your insurance, any remaining balance, but not to exceed $300, will be charged to your credit card. However, if a set of allergen vials is prepared, the total charge may be up to $1,500. Your signature below authorizes PACC to do so. You will be emailed and mailed a detailed billing statement monthly until the balance has been satisfied. You are responsible for paying your balance within 30 days of the statement's date. PAAC accept 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.

Patients with an outstanding balance overdue by 60 or more days must make arrangement for payment prior to being seen for further visits or allergy injections. If you have any questions regarding your bill, please call our billing department for assistance at 855-528-7348 ext. 704.

We reserve the right to forward your account to a collection agency/attorney for non-payment if it is 90 or more days overdue. If the account is sent for a collection, **a surcharge of 34 % will be added to the unpaid balance**. In addition to the amount owed, you will be responsible for the collection surcharge and any additional fees/costs permitted by law associated with the collection. You understand that the collection will have a negative impact on your credit rating.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Cancelled appointments deprive other patients of the opportunity to be timely seen and waste resources of our practice. Thus, appointment cancellations and/or rescheduling are to be requested at least 24 hours prior to the appointment. If you do not show for your appointment or cancel with less than 24 hours' notice, a **"no show" fee of $50 will be charged** to your account. Abuse of scheduled appointments may result in a discharge from the practice.

REPORTS AND SCHOOL FORM FEES:

You agree to pay an administrative fee of $30 for physician's review of records and preparation of progress, summary, discharge and other reports.

School forms and similar documents are to be requested and will be completed only during a scheduled appointment.

If you require completion of a school form outside of yours or your child's regular appointment, a processing fee of $15 will be charged per form for the completion within 3 business days or $20 per form if the same day completion is requested. The fees are payable at the time of the request.

CERTIFICATION

I certify that the information I have provided to PAAC 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: _____