ALLERGY & ASTHMA CLINICS OF OHIO

Payment Policy

Thank you for choosing Allergy & Asthma Clinics of Ohio. We are committed to providing you with quality and affordable healthcare. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions that you may have and sign in the space provided. A copy will be provided to you upon request. Thanks so much for being our patient.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO YOUR PAYMENT ARRANGEMENT.

Insurance We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may provide you with an estimate what your insurance company may pay, it is your insurance company, based upon your contract with them that makes the final determination of your eligibility and your financial liability for payments to us.

Claims Submission We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals If you have an insurance plan with which we are contracted you may need a referral authorization from your primary care physician/pediatrician. If we have not received a referral prior to your arrival at the office, we have a telephone for you to use to call your primary care/pediatrician physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Co- payments and Deductible All co-payments, deductible and co-insurance requirements must be paid at the time of service. This arrangement is part of your contract with your insurance company. Your contract with your insurance company may be in jeopardy if you do not pay your co-pay, deductible and/or co-insurance at time of service.

Proof of Insurance All patients must complete our patient information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage Changes If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum insurance benefits.

Methods of Payment We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Patient Statements If you have unpaid balance you will receive a statement by mail once a month. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to a collection agency for collections. Any payments made on an outstanding balance will be credited to the oldest outstanding balance.

No Show Fee Please cancel/reschedule your visits with 24 hours' notice. At our discretion, a fee equal to the cost of your office visit will be charged for any no show appointment.

Collection Fees: Balances that have not had a payment made within 90 days will be turned over to collections. Guarantor will be responsible to pay all costs of collections including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33 1/3%.

Interest If your bill isn't paid within 90 days there will be a 10% interest charge

Patient Name: _____

Responsible Party: _____

Signature: _____

Date: _____

Office Use: Received By: _____ **Date:** _____

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HIPAA PRIVACY NOTICES ACKNOWLEDGEMENT

Patient's Full Name _____ **Patient's Social Security Number** _____

Address, City, State, Zip Code _____ **Patient's Date of Birth** _____

Email Address _____ **Patient's Telephone Number** _____

I acknowledge that Allergy & Asthma Clinics of Ohio has offered me a copy of its Privacy Notice entitled **Your Information. Your Rights. Our Responsibilities** and that a copy of that document is available at Allergy & Asthma Clinics of Ohio. I have had the opportunity to review the document which explains how my Protected Health Information will be handled by Allergy & Asthma Clinics of Ohio.

Allergy & Asthma Clinics of Ohio asserts that they value the privacy of my Protected Health Information and will do everything in their power to protect my privacy. Information regarding my care and treatment will not be given to any individual (including my spouse, my children or my significant other or my parent(s) if I am over 18 years of age) without my written consent. If I want anyone other than my referring physician or my primary physician if I was referred by a specialist to have access to my medical information, I have listed their name and relationship to me below.

Name _____ **Relationship to Patient** _____

Name _____ **Relationship to Patient** _____

Information pertaining to my care, including reminders regarding appointments and/or immunotherapy or regarding billing issues and/or payment requirements may be left at the phone number listed above (either to the person who answers the phone or via a voice mail message) or via email at the above referenced email address. If I request that information be faxed, I authorize the staff at Allergy & Asthma Clinics of Ohio to comply with my request and understand that faxing is not the most secure method of communication and that my Protected Health Information may be available for public view.

I may revoke this authorization at any time by notifying Nancy Smith, Practice Manager, in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* _____ **Date of Individual's Signature** _____ **Date of Birth or Social Security Number** _____
(The person about whom the information relates)

Signature of Guardian* _____ **Date of Guardian's Signature** _____ **Relationship to Patient** _____
(If the patient is a minor child)