ASTHMA. &. ALLERGY MEDICAL CARE, PC

FINANCIAL AGREEMENT

We appreciate the confidence that you have expressed in selecting us as your physicians. If you have any questions regarding our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

A payment for your office visit is required at the time of service for:

- **Patients without insurance 6'**
- **Patients with private insurance**
- **Patients who are not covered by one of our contracted insurance plans. (PPO,HMO,EPO,POS,MC)**
- **Patients who do not provide us with contracted insurance information**

For Medicare and contracted insurances, we will bill all services at no charge as per the requirements of the insurance contract.

All monies owed by the patient (co-pays, deductibles and non-covered services) are payable at the time of the service. For patients with contracted insurance policies, all co-pays and deductibles are to paid each and every visit Patients with private insurance or no insurance are required to pay on their account each and every visit

Any patient that is seen or treated in our office, without prior authorization from their contracted group, is responsible for the full charge of the visit

Patients will be responsible for obtaining appropriate physician referrals before then-scheduled office visit, otherwise, payment in full will be required at the time of the service.

If you need to use a specific lab or x-ray facility-, you must notify the nurse before the service is rendered.

Any service that is rendered by this office, that is not a covered benefit of your insurance policy, is your responsibility to pay.

It is your responsibility to inform the office staff of any changes with your insurance coverage,

Our staff will assist you in dealing with your insurance company, but it is your responsibility to know and understand your own insurance policy.

It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstanding at a later date.

I have read and understood the above information.

Signature **Bate**

(Patient/Parent/Guardian)