

FINANCIAL RESPONSIBILITES

URGENT APPOINTMENTS are USUALLY brought in and seen the same day you call in. **If you need emergency care call 911 or go to the nearest Emergency Facility.** If you frequent our office for your allergy injections **and have questions for a nurse / doctor or if you are ill PLEASE CALL AND MAKE AN APPOINTMENT.** This allows us to book the appropriate amount of time needed with the Doctor this will reduce your wait time. **If you are more than 20 minutes late without notification to your appointment it may have to be rescheduled to another day, if possible we will work you in.**

CANCELLATION FEE:

All appointments that are not kept or canceled 24 hr in advance of your appointment will be charged \$30, canceling an appointment you must call the office do not use the after hour On Call Service This can result in additional fees for non-Urgent call. This fee will be charged to your account, Payable on or before your next appointment. TO ALL PATIENT: FAILURE TO KEEP OR CANCEL UP TO THREE APPOINTMENTS CAN RESULT IN THE DISCHARGE FROM ALLERGY ASTHMA SPECIALIST, THE DECISION TO DISCHARGE A PATIENT FROM OUR CARE WILL BE AT OUR DISCRETION. PLEASE DO NOT LET THIS HAPPEN TO YOU. New patient appointments are subject to a \$50 charge for appointments not canceled 24hrs in advance.

HMO /PPO /POS/MEDICARE HMO/ MEDICAID/TRICARE HMO PATIENTS:

YOU must obtain a prior authorization number/referral from your primary care physician before each visit or injection to our office. I understand if a referral/number is not issued MY APPOINTMENT WILL BE RESCHEDULED I understand I am responsible for any balance of unauthorized visits or procedures.

(Initial) _____

AUTHORIZATION AND RELEASE:

I **Authorize** ALLERGY ASTHMA SPECIALISTS, P.A. to **release or obtain** any/all information needed to file a medical claim and or treat, diagnose, prescribe medication, including my medical records and diagnosis of any treatment or examination rendered to me or my dependent during the period of such care, including, Office notes, Allergy test, Pulmonary Test, Labs, Radiology, my insurance company information, including third party payers and/or other health practitioner or medical facility including Medicare/Social Security Administration & Health Care Financing Administration or its intermediaries.

I **Authorize** my insurance company/Medicare/Social Security Administration & Health Care Financing Administration or its intermediaries to review any/ or all parts of my medical records, for the sole purpose of quality assessment and payment.

I **Authorize** ALLERGY ASTHMA SPECIALISTS, P.A. and the health care staff to perform the necessary medical services I or my dependent may need. **This consent is good for the entire time period I or my child(ren) am/are a patient.**

X _____ **Signature of Patient/Guardian** _____ **Print Name** _____ **Date:** _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Allergy Asthma Specialists, P.A. (AAS) of medical benefits or Medicare benefits otherwise payable to me under the terms of my policy for the claims filed by AAS, but not to exceed my indebtedness to AAS. In making this assignment to AAS, I understand and agree that any unpaid balances not covered by this policy/Medicare plan, **will be payable by me.** I authorize Medicare to make payment for services rendered directly to Allergy Asthma Specialists, P.A. **I understand I must provide current insurance information at each visit and a Photo ID.** I agree to be financially responsible for payment of all services on my behalf or my dependents.

I hereby certify the information provided is correct and true to the best of my knowledge.

X _____ **Signature of Patient/Guardian** _____ **Print Name** _____ **Date:** _____

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Payment must be paid at the time your appointment. This includes all Co-payments and deductibles. We accept Cash, Personal Checks, American Express, Master Cards, Visa and Discover, Secure Payments can be made Online via our Website, AllergyCFL.com There is a \$30 CHECK RETURN FEE for each check that is returned. If we get a NSF check only cash or credit card will be accepted in future. **If other financial arrangements need to be made, you must speak to our Business Office before your schedule appointment. I here by agree to AAS policy. AAS does utilize a collection agency for over due accounts.**

X _____ **Signature of Patient/Guardian** _____ **Print Name** _____ **Date:** _____