

# Baz Allergy, Asthma & Sinus Center

## Financial Policy

Thank You for choosing our practice. 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 THE ARRANGEMENT.**

**Insurance** We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

**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 and need a referral authorization from your primary care physician we will request it from your doctor. 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 physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. If you would like to call your primary care doctor before your visit please do so.

**Co- payments and Deductible** All co-payments- Deductible & Co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.

**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 will be responsible for the balance of a claim.

**Coverage Changes** If your insurance changes, please notify us before your next appointment so we can verify all your benefits.

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

**Patient Statements** If you have unpaid balance you will receive a statement by mail. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 60 days will be turned over to an attorney or collection agency for collections. All payments made go to the oldest outstanding balance.

**No Show Fee** Please cancel/reschedule your visits with 24 hours' notice. Cancellation in less than 24 hours or no-show will be charged a \$50.00 Fee.

**Collection Fees** Balances that have not had a payment made within 60 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.

Patient's Name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

*(please print name and relationship to patient)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_