

# ALLERGIC DISEASE AND ASTHMA CENTER, PA

## FINANCIAL POLICY

Thank you for choosing Allergic Disease and Asthma Center, PA for your allergy and / or asthma needs. We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we have developed the following policy to assist you in understanding and managing your financial responsibility.

Co-pays, deductibles and co-insurance for services are due at time of service, unless payment arrangements have been approved in advance by our billing department. High Deductible Health Plans or self pay patients will be required to pay a deposit of \$ 500.00 before procedures begin. Future appointments may not be scheduled until co-payments; co-insurance or deductibles are paid in full. We accept cash, checks, MasterCard, Visa, Discover and American Express. As a courtesy to our patients, we will be happy to submit your insurance claims and any other necessary information relative to your treatment. We accept assignment of benefits and a waiver must be signed for all non-covered or non-allowable charges. If you are self-pay or have no insurance, please call our billing department in advance to discuss payment options. Your account may be subject to a \$ 20.00 fee for prescriptions not obtained on the date of service.

Cash pay policy for uninsured patients have been adopted to offer a 20% discount for total charges if the patient or guardian pays in full using either cash or personal check for services rendered that day to include office visits and allergy injections. If check is returned for insufficient funds, the normal fee will be applied and the normal billing policy will apply with no further discounts to the patients account. Full payment can also be made by credit cards with an 18% discount. This discount includes 2% handling fee from the patients debit or Credit Card Company.

Return checks will not be re-deposited. Your account will be debited to reflect this outstanding charge plus an additional \$ 30.00 NSF handling fee. Balances older than 60 days will be subject to a \$ 4.00 monthly billing fee until paid in full. There will be a \$ 30.00 charge for all accounts that are turned over to an outside collection agency. Charges may also be made for missed appointments and appointments cancelled without 24 hours advanced notice.

We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. (Please refer to your personal health insurance policy for co-payments and/or co-insurance guidelines.) ADAC's fees are considered to be within the acceptable range for this area.
- **Not all services are covered benefits in all contracts.** Some insurance companies and/or employers arbitrarily select certain services they will not cover. **Regardless of insurance, payment remains your responsibility.** Once the insurance payment has been received, if the account is not paid within 120 days, the account will be placed with a collection agency. For billing and payment inquiries, please contact our business office at 864-627-3800, option 3.

Special Needs: We realize that temporary financial problems may make it difficult for you to pay your balance immediately. If such problems should arise, please contact the business department promptly. We are willing to work with you on your account, but it is your responsibility to inform us if you are unable to pay the outstanding balance.

**We must emphasize that our relationship is with you, not your insurance company.**

Filing insurance claims is a courtesy that we extend to our patients. All charges are your responsibility from the date the services are rendered.

If you have any questions about this information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

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

\_\_\_\_\_  
(Signature)

Revised: 3/4/2009