ALLERGY & ASTHMA CENTER

Waxahachie/ Mansfield

FINANCIAL AGREEMENT

INSURANCE

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referrals and authorization requirements. We will, however, assist you to ensure that all plan requirements are met. X_____ (PLEASE INITIAL)

PAYMENT FOR SERVICES

Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa and American Express. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative. X_____ (PLEASE INITIAL)

RETURNED CHECK

Returned checks will result in a $ 25.00 fee that will be posted to your account. Returned checks, balances older than 60 days, and failure to pay account balances attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt. X_____ (PLEASE INITIAL)

CANCELLED APPOINTMENTS

Charges may be made for broken, confirmed appointments cancelled without 48 hour notice. Your cooperation in canceling your scheduled appointment well in advance allows us the opportunity to offer your appointment to a person who needs medical care. X_____ (PLEASE INITIAL)

GENERAL

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

X_____ (PLEASE INITIAL)

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

Thank you,

My signature below constitutes acknowledgement and acceptance of this policy.

Patient Name:
(Please Print)

_____

Patient or guarantor Signature:

_____ Date _____