ALLERGY & ASTHMA CARE, INC.

NOTICE OF FINANCIAL RESPONSIBILITY

If you have health insurance and provided our staff with insurance information prior to your appointment, we will attempt to verify your eligibility, copay, and deductible status before you arrive at our office.

Based on the information obtained from your insurer, **you will be asked to pay one or more of the following on the day of your visit**:

- **Any applicable specialty care copay(s).**
- **Any applicable coinsurance percentage for all non-copay services** if your deductible has been met.
- **A 20% down payment, where applicable, for all non-copay services** if your deductible has not been met.
- **The total amount due for services already deemed "non-covered"** by your insurance.

Please note that any payment amounts requested and/or collected at the time of service are estimates only and based on the information provided to us at the time your eligibility is verified. Verification of eligibility does not guarantee insurance coverage or reimbursement for specific services. **Your total payment responsibility will not be determined until your insurer has processed your claim in accordance with the benefits available for the date of your visit.**

If you still have a balance due after your insurance has paid their portion, you will receive a monthly bill until the balance is paid in full. If you overpaid at the time of service, any credit on your account will be applied to other outstanding charges where applicable or refunded to you.

If you do not have health insurance, you will be responsible for all charges incurred during your visit. If you cannot pay in full at the time of service, please speak to our staff to make the necessary payment arrangements prior to your appointment.

Please complete and sign the following:

Patient Name (First) _____ (MI) _____ (Last) _____

Date of Birth ___ ___ /___ ___ /___ ___ ___ ___

I understand that all services provided by the doctors and staff of Allergy & Asthma Care, Inc. will be charged to my account and billed to my insurer(s) and/or to me where applicable.

I understand that it is my responsibility to know and understand my health insurance benefits, and also my right to refuse or postpone any recommended or offered services for any reason. This includes questions or concerns about my insurance coverage for those services, their ultimate cost to me, and/or my ability and willingness to pay that cost.

I understand that by receiving services without explicitly exercising that right I am accepting financial responsibility for all balances due to Allergy & Asthma Care, Inc. and will be billed accordingly.

Date __ __ /__ __ /__ __ __ __ **Signature** _____

(For patients under 18 years of age, parent/guardian must sign.)