ALLERGY ASTHMA
AND SINUS CENTERS

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(815) 729-9900

Financial Policy

Thank you for choosing Allergy Asthma and Sinus Centers as your healthcare specialist. We are committed to your treatment being successful. In order to achieve goals, we need your assistance and your understanding of our payment policy. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our financial department. We accept cash, checks, money orders, Master Card, Visa, American Express, or Debit Cards.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as a 50% or 80%) of "U.C.R.". "U.C.R." is defined as usually, customary, and reasonable.

   This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Insurance & Insurance Collection

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. Please initial next to your category of insurance listed below, as this will help us speed up the payment and eliminate any confusion in the future.

Plans in which we are participating providers:

[ ] **Cash Patient**

[ ] **Medicare**

[ ] **HMO Plans**
All co-pays must be satisfied each and every visit. There can be no exceptions due to contracting and uniform compliance rules. You solely are responsible for getting proper referral information in advance of your appointment.

[ ] **PPO Plans**
We have agreed to accept the discounted rate from your plan, however all co-pays/co-insurance/deductibles are solely your responsibility.

You are responsible for paying any co-pay, deductible and or co-insurance at the time of service. Our office staff makes every effort to be as accurate as possible when collecting these amounts; however, your insurance plan may not cover as much as we estimate. Any amount not paid by insurance is your responsibility. The undersigned also agree(s) to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency, in addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the court.

We must emphasize that, as medical care providers, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. 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 for unseen reasons you become

uninsured you must notify our office within 10 business days. If you have any further questions about the above information or uncertainty regarding your insurance coverage, **please do not hesitate to ask us**. We are here to help you.

No Show No Call appointments /Appointments that are not cancelled 24 hours prior to the scheduled time:

In the event that one of the above mentioned occurs, a valid credit card will be required to secure any future appointments.

There is a $25.00 fee per each occurrence. This fee will automatically be charged to your credit card.

I assign my insurance benefits to the Allergy Asthma and Sinus Centers inc.

X SIGNATURE OF PATIENT (PARENT IF A MINOR) **DATE:** MM - DD - YYYY