Financial Policy Agreement

This Financial Policy Agreement (the “agreement”), is by and between Allergy & Asthma Center of Texas, (“us” or “we”) and the undersigned patient (“you” or “yours”). Now therefore, in consideration of the services rendered and to be rendered and other good and valuable consideration, the receipt and sufficiency of which you acknowledge, you and we agree as follows:

Payments: You agree to pay us the fees we charge to your account for services and goods. The balance on your account as reflected in the statement we provide to you is due and payable in full when the statement is issued and is past due if not paid within 15 days. The word “account” means the account that has been established in your name to which charges are made and payments credited. By executing this agreement, you agree to be financially responsible for all services that are rendered to your account.

Monthly statement: If you have a balance due on your account, we or our billing office will send you a monthly statement.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

Required Payment(s): As required by your insurance carrier, any co-payment must be paid at the time of service.

Payment Options if you have no insurance:

1. You may choose to pay by cash, check, or credit card on the day that treatment is rendered. If you are paying for treatment in full, we offer a cash discount at the time of service.
2. If financial arrangements are needed, please speak with a member of the front office staff to discuss your options.
3. You may secure other third party financing for the entire amount and make payments to the lending institution.

Payment Options if you have insurance:

1. You may choose to pay your deductible and any out-of-pocket portions at the time of service by cash, check, or credit card.
2. If financial arrangements are needed, please speak with a member of the front office staff to discuss your options.

Insurance: The terms of your insurance coverage are a contract between you and your insurance company. We call to verify your benefits as a courtesy to our patients and we do our best to provide accurate information. Final determination of payment is made by your insurance company and should be addressed directly with them if you feel there is a discrepancy between your bill and your expected benefits.

Your doctor is contracted with most local insurance plans. It is your responsibility, however, to make sure your doctor is a contracted provider with your insurance. If your insurance requires a referral and/or pre-certification, we will assist you, but it is your responsibility to make certain this has been done prior to the date of treatment. Failure to obtain the referral/pre-certification required by your insurance carrier may result in lower payment or no payment by your insurance company.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to collection, you agree to pay any and all of the collection costs, including without limitation, all attorney fees and costs and a late fee of $20 which will be applied to your account for missed payments.

Divorce: In case of divorce or legal separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor child will then be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Initials: ________ Date: ________________

7002 Lebanon Road, Suite 103
Frisco, TX 75034
www.AACTMD.com
P: (972) 377-9987
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Returned Checks: There is a fee of $30 for any check returned by your bank. You agree to pay this fee, in addition to the amount of the returned check, by cash, money order, certified check, or credit card within 5 business days.

Waiver of Confidentiality: You understand that if your account is submitted to an attorney or a collection agency or if your past due account status is reported to a credit agency, the fact that you have received treatment at this office may become a matter of public record.

Contracted Lab: It is your responsibility to know which lab your insurance is contracted with prior to your appointment. This is to insure lab work and/or requisitions are sent to the correct lab.

COBRA: If at any time during your care your insurance benefits are considered to be COBRA, we need to be notified immediately. You must provide proof of current coverage at each visit, and you will be responsible for payment in full if your insurance company cannot verify the coverage for the dates of treatment.

Missed Appointment Fee: The 2nd time a patient does not show up for his/her appointment and/or cancels with less than a 24 hour notice, a $25 fee may be charged. We will not file this fee with your insurance company; you are responsible for the payment of this fee. Patients with three or more missed appointments may be asked to transfer their care.

Worker's Compensation, Medicaid, and Medicare: At this time our office has chosen not to accept these plans as payment for treatment.

Transfer of Records: You will need to sign a Medical Records Release form to have copies of your medical records sent to another doctor and/or organization. By releasing your medical records you authorize us to release all relevant information including HIV status. This may include payment history if used for legal purposes. If you would like a copy of your own medical records, there will be a $25 fee.

Co-Signature: In special circumstances a co-signature may be required. If this or any other Financial Agreement is signed by another party, that co-signature remains in effect until canceled in writing. When written cancellation is received, the co-signature becomes ineffective for any subsequent charges.

Credit Reporting: You authorize us to procure a consumer report and credit check on you and to report any matters to such credit reporting bureaus as we may determine. You consent to the release of such information orally or in writing, and hereby release any and all parties from all liability, claims and damages for any errors or other claims based upon any statements we make to any person.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions herein and this agreement will be in full force and effect.

I hereby authorize payment of medical benefits directly to Allergy & Asthma Center of Texas and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Allergy & Asthma Center of Texas. I further understand should my account become delinquent, I shall pay the attorney fees or collection expenses of Allergy & Asthma Center of Texas, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I am responsible for payment of services in full before the services are rendered.

____
Patient Name

____
Signature (Responsible Party)

____________/____________/____________
Date

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