

FINANCIAL POLICY for Northern Colorado Allergy & Asthma Clinic, LLC

Please understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients.

- ◆ We must emphasize that as a health care provider our relationship is with you, not your insurance company.
- ◆ Your insurance is a contract between you, your employer, and the insurance company.
- ◆ Contact your insurance company and/or your employer's human resource department with regards to your benefit questions.

PATIENT RESPONSIBILITIES:

Insurance Card(s): We require a copy of your current insurance card upon and with every antigen order.

We require your signature and a current card with every antigen order also.

Co-payments: **Co-payments are due at time of service.**

Referrals: If your insurance requires a referral, and you do not provide one at the time of service, you are responsible for any charges incurred.

Cancellations: **For all appointments there is a 24 hour cancellation notice requirement.**

There is a \$25.00 charge for repeated late cancels or no shows.

There is a \$50.00 charge for the same on new patient appointments.

If you have health insurance with which we participate:

- We will bill your insurance claim for you.
- We expect any required copayment at time of service.
- We expect payment of deductible and coinsurance to be paid in full after we have issued you a statement to be paid within 25 days unless prior payment arrangements have been made.

If you are uninsured or we do not participate with your insurance:

- We require you to sign an uninsured form.
- Payment for total charges are due in full on the day of your appointment unless you have signed a credit agreement with our office.

General:

Payment of services is due by the person accompanying any minor child unless other arrangements have been made in advance. We will not bill two people for care. It is the responsibility of the accompanying adult to pay the amount due in full, and collect what is owed by others.

We accept payments in cash, check and credit (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS). Post-dated checks are acceptable within 2 weeks and will be deposited on the check date.

There will be a \$15.00 charge for returned checks. Accounts over 90 days are subject to collection proceedings.

I have read and accept the terms of this financial policy.

Date: _____ Signature: _____

HOW WOULD YOU LIKE FOR US TO CONTACT YOU

For non-medical issues:

Phone () _____ U.S. Mail E-MAIL(non encrypted) _____ Patient Web Portal

For medical issues:

Phone () _____ OK Not OK to leave a message

U.S. Mail Patient Web Portal

I authorize the following individuals to inquire and receive verbal information regarding my care and signed medical release. (Actual release of medical records requires a separate form).

1. _____ Relationship _____ Date of Birth _____

2. _____ Relationship _____ Date of Birth _____

3. _____ Relationship _____ Date of Birth _____