ALABAMA ALLERGY & ASTHMA CENTER

(205) 871-9661

Acknowledgement Form for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge the use or disclosure of my protected health information by Alabama Allergy & Asthma Center, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Alabama Allergy & Asthma Center, LLC. I understand that diagnosis or treatment of me by the physicians of Alabama Allergy & Asthma Center, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Alabama Allergy & Asthma Center, LLC is not required to agree to the restrictions that I may request. However, if Alabama Allergy & Asthma Center, LLC agrees to a restriction that I request, the restriction is binding on Alabama Allergy & Asthma Center, LLC and physicians of Alabama Allergy & Asthma Center, LLC. I have the right to revoke this consent, in writing, at any time, except to the extent that physicians of Alabama Allergy & Asthma Center, LLC or Alabama Allergy & Asthma Center, LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Alabama Allergy & Asthma Center LLC's Notice of Privacy Practices prior to signing this document. The Alabama Allergy & Asthma Center LLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Alabama Allergy & Asthma Center, LLC. The Notice of Privacy Practices for Alabama Allergy & Asthma Center, LLC is also provided in patient reception area. This Notice of Privacy Practices also describes my rights and Alabama Allergy & Asthma Center, LLC's duties with respect to my protected health information.

Alabama Allergy & Asthma Center, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by reviewing the notices provided in patient reception area or by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Authorization and Consent for Treatment

The undersigned agrees, whether he signs as agent or as a patient, that in consideration of agreed upon services to be rendered, including allergy extracts and injections, by the Alabama Allergy & Asthma Center, LLC to the patient, he hereby obligates himself, assumes financial responsibility, and agrees to pay upon request to provider all charges for such services incurred by said patient. All deductibles, co-payments and co-insurance are due at the time of service. Should the account be referred to an attorney/collection agency for collection, the undersigned shall pay all responsible attorney fees and collection expenses, including any reasonable attorney fees and reasonable collection agency fees not to exceed 33 1/3%. The undersigned consents to treatment as determined and discussed with and agrees to medication history review and reconciliation. The undersigned understands that all bills are payable upon presentation and that he, not the insurance company, is responsible for the payment of the services. This office will file and collect from insurance when insurance benefits are present. All balances beyond the contracted insurance rates are payable by the patient due on receipt of a patient statement in the mail. I hereby authorize Alabama Allergy & Asthma Center to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered to patient. I acknowledge that all information regarding my identity is correct and accurate to my knowledge. By signing this document I understand that I am held accountable for any false information which could result in a fine or penalty and should notify the Alabama Allergy & Asthma Center, LLC if any of my information should change or if my identity is compromised or stolen.

Payment Policy

Thank you for choosing our practice. We are committed to providing you with quality and affordable healthcare. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions that you may have and sign in the space provided. A copy will be provided to you upon request. Thanks so much for being our patient.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals: If you have an insurance plan with which we are contracted, you may need a referral authorization from your primary care physician/ pediatrician. If we have not received a referral at least 24 hours prior to your arrival at the office, your appointment will be rescheduled.

Co-payments and Deductibles: All co-payments, deductible and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance: All patients must complete our patient information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment: We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Patient Statements: If you have an unpaid balance, you will receive a statement by mail monthly. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be will be turned over to an attorney or collection agency for collections. All payments made go to the oldest outstanding balance.

No Show Fee: Please cancel/reschedule your visits with 24 hours notice. At our discretion, a fee equal to the cost of your office visit will be charged.

Collection Fees: Balances that have not had a payment made within 90 days will be turned over to collections. Guarantor will be responsible to pay all costs of collections including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33 1/3%.