ALABAMA ALLERGY & ASTHMA CENTER™

Effective Date: January 1, 2016

Procedure Payment Policy

Rapid Desensitization, Aspirin Desensitization, Oral Challenges, Cluster Immunotherapy, Food or Drug Testing

PAYMENT IS DUE AT THE TIME OF SERVICE.

Thank You for choosing our practice! We are committed to providing you with quality and affordable health care. Our patients often have questions regarding patient and insurance responsibility for services rendered. To help answer these questions we have developed this document/policy. Please read it, ask us any questions that you may have, and sign the in 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.

A CREDIT CARD ON FILE IS REQUIRED FOR ALL PROCEDURES PRIOR TO SCHEDULING.

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. You or insurance benefit is a contract between you and your insurance company.

Referrals If you have an insurance plan with which we are contracted you need a referral authorization from your primary care physician/ pediatrician. If we have not received a referral prior to your arrival at the office, we have a telephone for you to use to call your primary care /pediatrician physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Copayments and Deductibles All co-payments- Deductible & 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 unpaid balance you will receive a statement by mail every two weeks. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt.

Interest Balances over 60 days will be charged 5% interest, for every additional 30 days overdue. All payments made go to the oldest outstanding balance.

Appointment Cancellation Policy
In the event that you, or your child, are unable to attend the appointment please contact the Procedure Coordinator Directly at (205)-209-4147 with at least two weeks notice to avoid being charged a $500.00 cancelation fee. If you do not cancel within two week and do not show up for your procedure a Missed Visit penalty fee of **$500.00** will be charged to your credit card. No exceptions will be made to this rule as we staff accordingly for each procedure we are providing.

I have read and understand Alabama Allergy & Asthma Center's ProcedurePayment Policy and agree to pay any charge not covered by my insurance company. I have also read the Appointment Cancellation, and No Show Policy and agree to abide by these standards. I understand my credit card on file will be charged if I cancel within two weeks or no show.

Patient Name	*Signature (if 12 yrs of age or older)*
Parent Name (Print)	*Parent Signature*
Physician Signature	*Witness*