Allergy Consultants, P.A.

FINANCIAL POLICY / PATIENT - GUARANTOR AGREEMENT

1. On my own behalf and on behalf of my spouse and minor children, including stepchildren, I hereby authorize treatment by Allergy Consultants, P.A.

2. I understand that payment of the required copay is due at the time of service. I direct and assign payment from any third party payer to Allergy Consultants. I understand that my insurance policy is a contract between me and the insurance company and that I am responsible to Allergy Consultants for any charges not covered by insurance. I also know that payment by the insurance company is not considered payment in full and that I am responsible for any amounts left un-paid by insurance, for any reason.

3. Should my insurance company require a specialist referral from my primary care physician before I can be seen by the physicians at Allergy Consultants, P.A., it is my responsibility to obtain that referral prior to my appointment as contracts with the insurance companies prohibit me from seeing the doctors without a referral. In the event that services are provided and my insurance is not in effect that day, or if my contract contains a pre-existing clause, I am responsible for payment as the patient - guarantor.

4. I hereby authorize the release of any and all medical and/or charge information as is necessary for third-party reimbursement from Medicare, Blue Shield and/or any other agency involved in payment of my treatment or that of my family.

5. I understand that I will be charged the finance charge of equal to 1% per month on any balance billed and left un- paid more than 30 days. I further understand that any amount left unpaid for more than 30 days will be considered delinquent, and may be referred to a collection agency or attorney as well as reported to the various credit reporting agencies. … .

6. If my account is referred to a collection agency and/o attorney for collection, I agree to be responsible for the payment of an additional collection fee in an amount equal to 30% of my outstanding balance, inclusive of accrued interest. I also understand there is a $ 20.00 returned check fee should a check be returned for any reason.

Signature of Patient/Responsible Party

I hereby acknowledge that I have received AND reviewed a copy of Allergy Consultant, P.A.'s financial policy and Notice of Privacy Practices.

Signature:_____

Relationship to Patient:_____

Date:_____

Printed Name of Patient:_____

Source: advocacy resource center of the American Medical Association 3 / 2014