**FINANCIAL POLICY**

**ALLERGY & ASTHMA ASSOCIATES OF MAINE, P.A.**

Thank you for choosing Allergy & Asthma Associates of Maine P.A. as one of your healthcare providers. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. The following is a summary of our Financial Policies and an explanation of your responsibilities. Please feel free to ask if you have **ANY** questions about our fees or your financial responsibility. By signing below you accept responsibility for your charges and authorize us to bill your insurance, on your behalf, for services provided to you.

**Your initial consult will result in average charges between $250.00 and $1000.00**. The initial charges include a consultation fee consisting of a detailed history and physical examination. There also will be fees for any testing (allergy skin testing and pulmonary function testing,) if performed during the course of your visit.  **Please Note\*\*\*\*** We will submit your claim for all services provided to your insurance company. Depending on your deductible and coinsurance, you may be responsible for all or part of the cost of your care, as determined by your contract with your insurance carrier. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed to have your insurance cover the charge. By presenting for care, you agree that you are responsible for all charges, regardless of your insurance status or coverage.

**WE MAY ASK TO SEE YOUR INSURANCE CARD AT EVERY VISIT IN ORDER TO KEEP OUR INFORMATION CURRENT.**

**REFERRALS:** If your insurance plan requires a referral from your Primary Care Physician, it is your responsibility to obtain it prior to your appointment. If you do not have a valid referral on file, you may be financially responsible for the visit or may need to have your appointment rescheduled.

**CO-PAYMENTS:** Some health insurance carriers require the patient to pay a co-pay at the time of service. Please be prepared to **pay your co-pay at the time of your appointment**. Co-payments that are not paid at the time of service will be billed to you with an **additional $10 fee** for administrative costs, postage, billing time, supplies, etc.

**SELF-PAY:** If you do not have insurance coverage, we are happy to work with you to set up a payment plan. If you are a new patient, a $250.00 deposit will be required at your first visit, prior to seeing the provider. Allergy testing will not be performed on your first visit unless you have talked with our billing specialist and arranged for payment.

**RETURNED CHECK FEES:** Any check returned from the bank for non-payment (insufficient funds), shall result in the patient’s account being charged a $25.00 fee per returned check.

**DIVORCE:** In divorce situations, the parent who brought the child in is responsible for payment of the bill. We will file with any insurance company we have a contractual agreement with.

**MONTHLY STATEMENTS:** Any outstanding balance is due immediately upon receipt of our statement. We accept payment by Visa, MasterCard, Discover or check. Failure to pay your balance or set up payment arrangements within 90 days may result in the account being turned over to our collection agency and the patient being discharged from the practice.

**Missed Appointments:** We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we require 24 hrs notice for all cancelled appointments. New Patients that miss an appointment will be charged a $75.00 reinstatement fee to reschedule. If you are an established patient and fail to give 24 hrs notice to cancel your appointment or do not show up for your appointment, a $50 missed appointment fee will need to be paid to reschedule the appointment. More than two missed appointments may result in the patient being discharged from the practice. The Practice will notify you in writing, via certified mail, if you are discharged from care. Please realize that a missed appointment leaves an opening that could have been filled by a patient waiting to be seen in our office.

**Patient Name:**

**PATIENT/PARENT SIGNATURE DATE:**