ALLERGIC DISEASE ASSOCIATED, P.C. T/A THE ASTHMA CENTER
Financial Policy

Welcome to Allergic Disease Associates, P.C. T/A The Asthma Center ("Practice"). We are committed to providing you with the best care possible.

The following is intended to clarify our financial rules and payment practices for the benefit of our patients. This financial policy is a legal arrangement between the Practice and its patients. By signing below, you, as our patient (the patient's legal representative, as applicable) agree to abide by its terms and requirements. Your clear understanding of this financial policy is important to our professional relationship.

Please also note that information in this Policy is not intended to be interpreted as legal advice or as interpretation of the terms of patient's insurance policy or benefit plan. Patients must refer any questions regarding medical services coverage, amount of coverage, co-payments, deductibles, out of pocket costs, mandates, claim adjudication, appeal, etc. to their carrier or legal counsel.

I. INSURANCE

At each visit, please bring identification (e.g., current driver's license or government issued ID) and a copy of your current insurance card. Payment for services is due at the time services are rendered, except as outlined below. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide accurate and timely insurance information. Inaccurate or untimely information given to our staff that results in denial or noncoverage by your insurance company results in the guarantor named on the Insurance/Guarantor Information Form being responsible for payment. If your insurance changes, it is your responsibility to notify us in a timely manner and verify that we accept your new insurance plan.

II. NON-EMERGENCY APPOINTMENTS

Routine follow-up, allergy injections and the like may be rescheduled if there are outstanding balances or if a co-payment is not made at time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer (if you are insured by a group employee benefit plan), and your insurance company. ***It is important for you to be an informed consumer who understands the specifics of your insurance policy (e.g., vaccine and doctor visit coverage, referral/authorization requirements for specialty care, X rays, laboratory tests, emergency hospital care, etc.).***

III. BILLING

It is our policy to require all patients to always have a valid credit card on file with us. Please refer to our Credit Card Authorization Form on the last page of this policy. We provide you with an itemized statement monthly as well as when requested. We accept cash, checks, MasterCard, Visa, Discover, or American Express. For your convenience we also offer online payments through a third-party business associate we have hired to process our payments via our website. **Outstanding balances are due within 30 days, unless prior arrangements have been made with the billing department**. A $15.00 billing fee will be charged to you if your co-payment is not made at the time of service. Individuals with balances not paid in full within 90 days of the initial statement date will receive a final notice letter that will inform you that your account will be forwarded to a collection agency within 30 days. An additional collection fee imposed as a percentage of the balance owed will be charged on all collection accounts. If your account is forwarded to a collection agency, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new provider who can continue your medical care. Please note these fees are not covered by your insurance company.

A $45.00 fee will be charged for all returned checks and your account will be placed on a "cash-only basis service." We will accept payments only by cash or credit card until the balance is cleared.

We will attempt to collect any unpaid balance to the extent we are allowed by law, regardless of whether you are still a patient. However, we realize that temporary financial problems may affect the timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Should your account balance become uncollectible due to bankruptcy, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new provider to continue your medical care.

You authorize us to charge your credit card for all charges incurred for dependent patients even if you are not the guarantor or other responsible person for such charges under the applicable insurance policy or otherwise.

IV. IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY (In network insurance)

You are responsible for paying all co-payments and/or out-of-pocket costs at the time of service and are subject to a $15 billing fee if not paid at the time of service. Generally, you will be notified directly by your insurance company with an Explanation of Benefits (EOB) statement after your services have been considered and adjudged by your carrier for payment. You may also be notified of your annual deductibles and coinsurances payments. Any unpaid balance owed to us will be billed to you consistent with the explanation of benefits (EOB) from your insurance. As a courtesy to you, all services performed in our office will be submitted to your insurance on your behalf.

All in-network insurance carriers have a fee schedule from which they will reimburse. However, the doctor's fee may be higher than what the insurance company reimburses, or it may not be a covered service. Therefore, any balances not covered by insurance become the responsibility of the patient. In the event the patient wishes to dispute the carrier's benefit payments, he/she/they must follow the claim appeal or review process required by the terms of their plan or policy. If you prevail in the appeal or review process, we will credit or reimburse you for the additional payments we receive from your insurance carrier.

V. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY (out of network insurance)

If we do not participate in your insurance plan, we are not able to bill your insurance and we cannot accept payment from your insurer for our services. If we do not participate with your insurance, we can still provide you with medical care, however, you will be responsible for full payment of services at the time of your visit(s).

Patients will be responsible for contacting their insurance to ensure they have out of network benefits and to understand their out of network benefits coverage and the out-of-pocket costs. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. Not all services provided by this office are covered benefits in all contracts. Patients are financially responsible for all services which may be more than the allowable amount of your insurance plan. Any payment for services is due at the time of service. A $15 rebilling fee will be added to balances not paid at the time of service.

VI. DIVORCED/SEPARATED PARENTS OF PATIENTS WHO ARE MINORS

Our focus is only your child's medical care. We are not party to or will not be involved in any legal issues involving custody agreements. Parents of patients who are minors must comply with the following requirements in addition to the items enumerated above:

- The Practice must have a copy of the Custody Court Order on file in the minor patient/child's chart.

- A minor child's health records will only be made available to the custodial parent recognized by a court order and/or to his/her legal representative.
- Consistent with the terms of this Policy, the child(ren)'s current insurance policy information must be kept on file with our office and must be updated as needed. Consistent with the terms of this Policy, the parents must maintain a current credit card on file with our office and must be updated as needed. Payments for services rendered, including co-pays, deductibles, coinsurance, or any additional fees charged by your insurance carrier, are due at the time of service regardless of which parent is responsible for medical expenses.
- We will collect payment from the parent who brings the child(ren) to their visit. Any disputes regarding nonpayment for services rendered will be referred to collections per the terms of this Policy. Any unpaid services will be due at the next time of service, or the patient will not be seen.
- Custodial decisions regarding appointments, vaccinations and/or any office procedures MUST BE MADE PRIOR to visiting our Practice.
- If there is NOT a court order on file with our office,
    - Either parent or legal guardian can sign a "consent to treat" form and authorize any named individuals (like grandparents, nannies, etc.) to bring your child to our practice, be present during the visit and consent to any treatment during that visit. Either parent or legal guardian can schedule an appointment for their child, be present for the visit, and/or obtain a copy of the visit summary.
    - It is both parents' responsibility to communicate with each other about the patient's care, office visit dates and any other pertinent information relevant to the patient.
    - Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless authorized by law or tolerate appointment scheduling/canceling patterns which in our judgment becomes evident by the behavior of either parent.

The Practice reserves the right to discharge the child(ren) from the practice should the provisions of this Policy not be followed and/or, if in our judgment, any behavior of the parties appears to be non-compliant with this policy and in our judgment, compromises patient care.

VII. BIOLOGIC INJECTIONS

Almost all insurance plans require biologic injections to be authorized prior to the initiation of the therapy. Our office will work with your insurance company to obtain the prior authorization. This may at times be a lengthy process, however, most requests are resolved within a two-week period. In order to maintain your therapy schedule it is imperative that if/when you have an insurance company change you inform our office immediately so that a new prior authorization process can be initiated. If you present new insurance information to the office at the time of your visit without the required prior authorization from your insurance carrier, you will **NOT** receive your biologic injections at that time.

VIII. MEDICARE

The patient is responsible for the annual deductible and/or 20% of the Medicare allowable for all covered services.

IX. COVERED SERVICES AND SELF PAY

If our services are not covered by your insurance plan or if you have no insurance, you agree you will be financially responsible for all charges. If the patient is a dependent, you are financially responsible for all charges even if you did not accompany the patient to our office for treatment."

IX. MISSED APPOINTMENTS AND/OR LATE CANCELLATIONS

Missed appointments represent a cost and inconvenience to us and to other patients who could have been seen in the time set aside for you. For cancellations, 24 hours' notice prior to the appointment is required. For new patients, failure to

provide 24 hours' notice of cancellation or failure to come to your appointment will result in a $75.00 fee. For follow-up appointments, failure to provide 24 hours' notice of cancellation or failure to come to your appointment will result in a $50.00 fee. An $85.00 to $150.00 fee will be charged for any missed appointment for special testing (e.g., allergy testing, drug or food challenge or desensitization). A credit card on file is required when booking and charged accordingly for missed appointments. We reserve the right to discharge patients who miss multiple appointments, fail to give 24 hours prior notice of cancellation, repeatedly cancel appointments or repeatedly do not show up for scheduled appointments. Please note these fees are not covered by your insurance company.

X. FORMS AND FEES

There is a $20.00-$30.00 fee for the review and completion of forms such as Short – Term Disability, FMLA, ETX.. The fee depends on the type of form to be completed. Additionally, there is a charge for requests of medical records, in compliance with state or federal mandates related to copies and release of medical records.

XI. REFERRALS

If your insurance plan or policy requires a referral for you to see a specialist, or for procedures or allergy injections, you are responsible for requesting, obtaining and keeping track of all referrals in a timely manner. If you do not have a valid referral you may have to reschedule your appointment, subject to Item VII of this Policy. If a referral form is not presented at the time of service, or was not obtained on time, the patient will be responsible for payment in full at the time of service, in accordance with Item II of this Policy.

XII. MEDICARE ASSIGNMENT FOR MEDICARE PATIENTS - MEDICARE RELEASE

Under the Medicare Law, effective 9/1/90, it is our obligation to process Medicare claims for our patients. In order to comply with this law, it is necessary that we have you sign the following statement:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Allergic Disease Associates, PC for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for the related services."

The Asthma Center team thanks you for choosing to receive your care at The Asthma Center. It is our pleasure to care for you.

Signature of Patient or Legally Authorized Representative):

Name: _____
Relationship to patient:

Witness: _____
Date: _____

XIII. THE FINANCIAL AGREEMENT

We must emphasize that as specialty providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE

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DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you. When you become a patient at our office, we will ask you to sign a copy of our financial policy. Please prepare for your first visit by signing our financial policy in advance.

The Asthma Center team thanks you for choosing to receive your care at The Asthma Center. It is our pleasure to care for you.

ACKNOWLEDGMEN OF RECEIPT
OF ALLERGIC DISEASE ASSOCIATES, PC, T/A THE ASTHMA CENTER
FINANCIAL POLICY AND AGREEMENT:

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY FROM ALLERGIC DISEASE ASSOCIATES, PC, T/A THE ASTHMA CENTER. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION, OUR PRACTICE COLLECTION FEE, ANY LEGAL COSTS OR COURT COSTS, IN ADDITION TO THE ORIGINAL AMOUNT DUE, AS THE LAW ALLOWS.

IN ADDITION, I UNDERSTAND AND AGREE TO RECEIVING INFORMATION FROM THE PRACTICE VIA EMAIL. BY THIS AUTHORIZATION I ACKNOWLEDGE THAT THERE MAY BE INHERENT RISKS ASSOCIATED WITH ELECTRONIC COMMUNICATIONS, INCLUDING POTENTIAL DELAYS, DATA LOSS, UNAUTHORIZED ACCESS, AND SECURITY BREACHES. FURTHERMORE, I ACKNOWLEDGE AND AGREE THAT IT IS MY RESPONSIBILITY TO SECURE MY ELECTRONIC COMMUNICATION SYSTEMS TO ENSURE THE SECURITY OF SENSITIVE INFORMATION SENT TO ME. I HEREBY WAIVE ANY CLAIMS AGAINST ALLERGIC DISEASE ASSOCIATES, PC T/A THE ASTHMA CENTER (THE "PRACTICE") FOR DAMAGES ARISING FROM THOSE RISKS ASSOCIATED WITH ELECTRONIC COMMUNICATION SYSTEMS AND AGREE TO USE THE SERVICE AT MY OWN RISK.

I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO ME AS THE PATIENT/GUARANTOR.

Name of Patient _Please Print:_____Date:_____

Signature of Patient

or Legally Authorized Representative: **Date:**

_____

(RELATIONSHIP TO PATIENT- PLEASE PROVIDE GUARDIANSHIP OR CUSTODY OR LEGAL APPOINTMENT DOCUMENTATION)