AVANT ALLERGY & ASTHMA

Financial Agreement and Credit Card Authorization Form

Patient Name: _____ **Date of Birth**: _____

Thank you for choosing Avant Allergy & Asthma for your healthcare needs. We are committed to providing you with the best possible medical care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Please read and sign prior to your first visit. Our practice firmly believes that good patient relationships are based upon understanding and good communication.

- **Your Responsibility**:
  1. It is your responsibility to provide us with accurate information so that we can file your claims correctly, including copies of your insurance card(s) and photo identification. If your address, telephone number, or insurance changes, please notify us immediately. If your insurance changes, it is your responsibility to verify that we are contracted with your new plan.
  2. Any co-payment, deductible, or coinsurance responsibilities are to be paid at the time of service.

- **Referrals**: If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. A referral requirement is the result of your contract with your insurance company, therefore it is your responsibility to obtain/secure it prior to your appointment and have it with you at the time of your visit. If your insurance company denies payment because a referral was not obtained, you will be responsible for the cost of the visit. You are responsible for any balances classified as "Patient Responsibility" by your insurance company. Any dispute with claim processing is between you and your insurance company.

- **Insurance Policy**:
  1. Our facility participates with a variety of insurance plans. Our staff will inform you what insurance plans we accept. If we do not participate with your insurance plan, we can still care for you but you will be responsible for the full payment at the time of service. As a courtesy, we will file a claim with your insurance, for services rendered. If your insurance company denies coverage or any amounts are unpaid, they will be billed to you. Since the relationship is between you, the subscriber, and your insurance carrier, you will be responsible for obtaining payment after that point. Payment of any outstanding amount will be expected from you.
  2. If you have any questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (the number is on the insurance card) or the employer's human resource department. A list of common codes we use can be found on our website www.avantny.com.
  3. If you have any questions about your insurance, we are happy to help you. We ask that you review your insurance policy to be fully aware of any limitations of the benefits provided. Specific coverage issues, however, should be directed to your insurance company member services department prior to your visit (the number is on the insurance card) or the employer's human resource department. A list of common codes we use can be found on our website www.avantny.com.

- **Appointment and No Show/ Cancellation Policy**:
  1. We attempt to accommodate patients' appointments by scheduling at their convenience. As a courtesy, we will remind you of your appointment by calling and/or texting/emailing you prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event that your mailbox is full or your line is busy our efforts to contact you may be unsuccessful. An

appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients.

2. We request cancellations be done at least 24 hours prior to the scheduled visit. If you cancel less than 24 hours prior to your scheduled visit or are a no show, we reserve the right to charge a fee of $75.00.

   You will be reimbursed your $75.00 charge, if you complete your visit at another date and time. If you cancel the rescheduled visit, you will be charged another $75.00 fee.

   Please note that the $75.00 cancellation fee cannot be submitted to insurance and is the sole responsibility of the patient.

   Please make every effort to attend your scheduled visit.

- **Patient Parent or Guardian Responsibility**: If the patient is a minor, (17 years and younger), the parent or guardian who accompanies a child to their Allergy & Immunology appointment has authorization to consent to medical care as needed and is responsible for payment of medical services. It is the parent or guardian's responsibility for payment of all Allergy & Immunology services provided by Avant Allergy & Asthma in accordance with the practice's fees and terms. In the case where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment. All parents under 18 years of age must be accompanied by a parent or guardian to their initial visit as well as all visits where testing or procedures will be performed or for allergen immunotherapy (allergy shots). After the initial visit, a parent or guardian may sign our Preauthorization to Treat Minor form allowing us to render care to children sixteen (16) or seventeen (17) years of age for follow-up visits only without the presence of a parent or guardian.

- **Assignment and Release**: I authorize payment to be made directly to Avant Allergy & Asthma by my insurance company, and I accept financial responsibility for all services not covered by my insurance. Copayment, deductible, co-insurance, and self-pay payment responsibilities are to be paid at the time of service. For your convenience we accept cash, checks or credit cards (i.e. VISA, Mastercard, Discover and American Express). I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information. You can provide authorization to charge your credit card at the bottom of this form.

- **Testing**: You may require diagnostic testing as part of your evaluation and treatment. By signing this form, you acknowledge that you are aware that testing may apply towards your deductible and/or co-insurance and that you have reviewed your benefits with your insurance company prior to undergoing this testing.

- **Allergy shots**: If you are an allergy patient who is consenting to receive allergy shots as part of your treatment plan, it is important that you understand your benefits and responsibilities related to the cost of this type of therapy. Once you consent to receive allergy shots, your doctor will write a prescription for allergy serums specifically for you based on your particular allergies. Our office will verify insurance coverage and will notify you if there are any large out-of-pocket expenses before preparing the serums and submitting a bill to your insurance company. If there is a large out-of-pocket amount due on your part, we can discuss a payment plan, or you may decide to decline to receive allergy shots.

  Alternatively, if only a copayment is due, then the office will prepare your serums and submit a charge for the vials to your insurance company. The office will notify you when the vials are ready so you may schedule an

allergy shot visit. At each of these visits, you will be billed for the administration of the injection. A copayment will generally also be due at each of these shot visits.

- **Credit Card Policy**: We request that every patient store a credit card on file. Your credit card information will be stored securely. For your convenience we accept VISA, Mastercard, Discover and American Express. We will submit a bill for every office visit and await payment from your insurance company. If a portion of the bill applies to the patient's responsibility, your credit card will be used to secure that portion. The Explanation of Benefits (EOB) will be provided by your insurance company and it will provide all necessary details. Charges that do not successfully process or are denied through your credit card will remain your financial responsibility. Any charge that has not been paid within 30 days from the last visit, will incur a late charge of $35.00 Any account that has not been paid 90 days from the explanation of benefits, will be sent to collections. We will not be able to reverse any accounts that have been sent to collections.

  If you choose not to leave your credit card on file, you must pay your estimated costs on the day of the visit. Any fees that are to be returned will be done so within 30 days of notification from your insurance company to our office.

Credit Card Type: ____Visa ____Mastercard ____Amex ____Discover

Name of Credit Card: _____

Credit Card Number: _____

Expiration Date: _____ **CVV Code**: _____ **Billing Zip Code**: _____

We are committed to providing you with the highest quality of health care and are happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

By signing this form below, I agree to and understand the policies set forth above:

Patient Name: _____ **DOB**: _____

Responsible Party Signature: _____ **Date**: _____

Print Name *(if Responsible Party is other than self)*: _____