ALLERGY & ASTHMA CENTER OF THE ROCKIES
FINANCIAL POLICY

Please understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you to ensure that your medical care does not become a financial burden. We will gladly bill your insurance company for any covered services.

We must emphasize that as a health care provider our relationship is with you, not your insurance company.
Your insurance is a contract between you, your employer, and the insurance company.
Contact your insurance company and/or your employer's human resource department with regards to your benefit questions.

PATIENT RESPONSIBILITIES:
Insurance Card(s): We require a copy of your current insurance card upon every visit and with every antigen order. We also require your signature and a current card with every antigen order.
Co-payments: **Co-payments are due at time of service.**
Referrals: If your insurance requires a referral, and you do not provide one at the time of service, you are responsible for any charges incurred. It is your responsibility as the insured to obtain a referral.

Cancellations:
For all appointments there is a 24-hour cancellation notice requirement.
There is a $25.00 charge for repeated late cancels or no shows, that can ultimately result in dismissal from the practice.
If you have health insurance with which we participate:

- We will bill your insurance claim for you.
- We expect any required co-payment at time of service.
- We expect payment of deductible and coinsurance to be paid in full after we have issued you a statement to be paid within 25 days unless prior payment arrangements have been made.

If you are uninsured or we do not participate with your insurance:

- We require you to sign an uninsured form.
- Payment for total charges is due on the day of your appointment unless you have signed a Payment Plan with our office.

General:
Payment of services is due by the person accompanying any minor child unless other arrangements have been made in advance. We will not bill two people for care. It is the responsibility of the accompanying adult to pay the amount due in full and collect what is owed by others.

We accept payments in cash, check and credit card (VISA, MASTERCARD). Post-dated checks are acceptable within 2 weeks and will be deposited on the check date.
If payment arrangements need to be made, they must be made prior to any service and payment in full must be within 90 days. Accounts over 90 days are subject to collection proceedings. I understand that should the account be turned over to collections I may be held responsible for any and all collection, legal and attorney fees incurred. Account balances are to be kept under 60 days old, or further services (ie: injections, office visits) may not be provided until payment is made in full or a payment plan with a credit card on file is agreed upon.

- **There will be a $25 charge for returned checks.**
- **I have read and accept the terms of this financial policy.**
- **I understand this pertains to current and any future treatment I receive.**

I authorize the release of medical information necessary to process claims or obtain treatment. I authorize payment be made directly to the clinic for services provided. I understand I am responsible for services not reimbursed by my insurance. I understand I am responsible for obtaining referrals for services needed and I will be charged for those services received without a referral in place. If payment arrangements need to be made, they must be made prior to any service or immediately upon receipt of the initial statement; payment in full must be made within 90 days. Accounts over 90 days, or any missed payment of your payment arrangement, are subject to collection proceedings.

Date: ___________________________ Signature: ____

©ALLERGY & ASTHMA CENTER OF THE ROCKIES 9/2019