



FAMILY ALLERGY CENTER

13890 Braddock Road, Suite 206
14535 John Marshall Highway, Suite 212

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Registration Policies

Patient Name: _____

Date: _____

Welcome to the Family Allergy Center. In an effort to provide the highest level of care and insure patient satisfaction, the following policies and expectations are described below. This form confirms that patients understand services being provided at the FAC are necessary and appropriate. This form advises patients of their financial responsibility for all medical services received without regard to insurance eligibility or coverage determination. These financial responsibilities might also extend to services or tests requested by the patient but not deemed medically necessary. You must be 18 years or older to consent to treatment. You must be the insured/parent/guardian or the policy holder to consent to the financial responsibility for treatment.

CONSENT TO TREATMENT _____(initials)

The patient hereby consents to the administration of such medical treatment, diagnostic tests and/or therapeutic procedures as required by the provider rendering care for themselves and/or their children. The procedures may include but are not limited to skin testing, pulmonary function testing, injections, laboratory or radiological services.

REFERRALS _____ (initials)

I understand that it is my responsibility (if my plan requires referrals) to obtain appropriate referrals to receive medical services as required by my plan. The referral must be in the office prior to the appointment or carried in hand at the time of the appointment. The practice cannot see any patient without a referral. Appointments will be rescheduled if no referral is "in hand". Furthermore, I accept all responsibility for any unpaid/rejected/or processed "out of network" claims due to failure to have correct, accurate or appropriately dated referrals.

SPECIALISTS _____(initials)

I understand the FAC is considered a specialist. As such they do not provide primary care. I agree to have a primary care physician. If I do not have a PCP, the practice will assist me in finding one. Routine physicals, non-allergic problems, acute infections, fever and emergencies will be handled by my PCP.

FEES _____(initials)

Patients who do not present for an appointment for regular follow-up or fail to cancel 24 hours prior to their appointment will be charged a no show fee of \$50. Patients who fail to keep an appointment for ANY specialty testing will be charged a fee of \$100. This fee will need to be paid prior to rescheduling. This fee cannot be filed to insurance. No shows are documented in the patient record. The practice also has fees for school forms, letters and any form or service that requires professional staff time.

LATE ARRIVALS _____(initials)

As a courtesy to all of our patients, patients who arrive late for a scheduled appointments may be asked to reschedule.

FINANCIAL POLICY – PLEASE READ CAREFULLY

Patients or their legal representatives are ultimately responsible for all charges for services rendered. Payment is expected at the time of service for all charges owed for the current visit as well as any prior balance. For those with insurance, estimations of patient responsibility based on contractual obligations will be collected at the time of service.

TYPES OF PAYMENTS

- Copayments – **FAC is required by insurance carriers to collect copayments at the time of service.** The patient's appointment may be rescheduled if he/she is not prepared to make this payment.
- Deductibles – Some insurance plans require patients to pay a predetermined amount before services will be covered. **Deductibles are verified and payment is collected at the time of service**
- Co-insurance – Some insurance require that patients pay a predetermined percentage of the allowed charge. If the amount can be determined at the time of service, it will be collected.

PLANS WITH DEDUCTIBLES: _____ (initials)

For plans with deductibles, deductibles are due at the time of service. If, after careful consideration and contact with your plan, an accurate patient balance was not determined at the time of service, the patient has two choices:

CIRCLE ONE:

- 1) Leave a credit card on file

Card Information:

Name as it appears on the card: _____

VISA/MC/AMEX/DISCOVER Card Number: _____

Expiration date: _____ Security code: _____

- 2) Once your EOB returns to the office with the amount due, you will receive a call and payment over the phone is expected. This is a courtesy extended to our patients. The two phone numbers you would prefer to be contacted:

() _____

() _____

FAC does not wait for bills to be generated before collecting balances. Bills serve as a reminder of amount owed.
_____ (initials)

Failure to pay balances on time will incur a 20% service fee. (_____ (initials)

Un-insured patients – Payment for all services rendered is due at the time of service.

Out-of Network – Patients being seen Out of Network will be required to pay the entire balance at the time of service. We will courtesy bill your insurance company.

Non-Covered Services – In this practice “non-covered” services means any services rendered that was not paid under a patient’s insurance contract. Patients are responsible for any non-covered service. _____(initials)

If a patient is unsure whether a service is covered by his/her plan or that a plan maximum may apply, it is ultimately the patients responsibility to call his/her plan to determine what the schedule of benefits allows. If non-covered services are provided, the patient will be expected to pay for the services at the time of service. No contractual discount will apply to non-covered services. Appeal procedures are generally available by request and the billing staff will assist patients in attempting to resolved adverse determinations. Under no circumstances will billing staff or medical staff change a diagnosis, symptom or service date in order to obtain coverage for services.

PLEASE NOTE: Non-covered services, denied services, services over maximum plan benefits or services denied for any reason do occur in the practice of allergy and immunology. They are plan specific and the practice has no way of knowing the subtle plan limits for each and every carrier. Ultimately, the patients insurance is a contract between the subscriber (the patient) and the individual insurance plan you have chosen. FAC is not part of this contract. The patient agrees to pay all non-covered services, denied services, services over maximum plan limits and services denied for any other reason _____(initials)

VERIFICATION OF INSURANCE _____(initials)

I agree to provide updated and accurate insurance coverage information so that my claims may be filed in a timely manner. Failure to provide my current valid insurance card at the time of service will result in my claims being processed as an un-insured patient (refer above to policies for un-insured patients). The decision to retroactively file claims once a valid card is received will be determined by the practice and is not guaranteed.

SECONDARY INSURANCE _____(initials)

FAC does not file secondary insurance claims.

Outstanding Balances _____(initials)

Any outstanding balance that is due from the patient/family accounts is payable in full upon receipt of insurance EOB or office statement. In the event a patient presents for an office visit, allergy shot or serum refill and has an outstanding balance, a request for payment will be made and balance collected that day. This includes routine allergy shots administered weekly, office visit balances, and serum balances or balances. After 90 days from the date of service, outstanding balances are referred to an outside collection agency. A patient with unpaid delinquent accounts, accounts in collection or accounts which have been written off to bad debt may not receive additional services unless special arrangements are made. The patient may also be discharged from the practice.

Patient Name: _____

Date: _____