Abilene Allergy
Dr. Ashley Hall, M.D.
Allergy, Asthma & Immunology
Dr. Gary Goodnight, D.O.
Ears, Nose, & Throat

3 Hospital Drive
Abilene, TX 79606
325-437-3600
325-437-2395 FAX

Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our Practice Administrator. We are dedicated to providing the best possible care and services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Office Visits:

- If you do not have insurance, payment is due at time of service. Uninsured new patients are required to pay $150.00 at the time of the first visit, which will be collected when you arrive for your appointment. This amount does not include any testing.
- **It is the policy of our office to collect any co-payments or any outstanding balances when you arrive for your appointment.**
- If you have insurance coverage with a plan that has no set copay we will collect the allowable rate. However, you will be fully responsible for any amount that your insurance does not pay.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

Allergy Services:

- The practice will accept assignment on allergy services. However, the manner in which insurance claims for allergy services are paid varies greatly from company to company and policy to policy. The average cost of Allergy Testing varies depending on the test being performed. Prior to beginning allergy treatment, please arrange to speak with the Billing Supervisor or the Practice Administrator regarding what to expect financially. **You are responsible for any amount that your insurance company does not pay, subject to managed care contract rules.** <u>If the account is not kept current, allergy treatment is subject to suspension. All vial balances during the build-up phase must be paid in full in 6 weeks or prior to staring a new vial whichever comes first. Once maintenance has been reached you have 6 weeks to pay your vial fee.</u>

Minor Patents:

- For all service rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to time by the practice.

_____
Print Patient Name

_____ _____
Signature of Patient/Responsible party, If Minor Date

_____ _____
Witness Date

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Assignment of Benefits Form

Financial Responsibility: All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

I have requested medical services from **Abilene Allergy,** on behalf of myself and/ or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the day that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier (s), including Medicare, private insurance and any other health/ medical plan, to issue payment check(s) directly to **Abilene Allergy** for medical services rendered to myself and/ or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Patient Consent for Disclosure of Information: I have read the Notice of Privacy Practices and have had any questions answered by this office. I understand that by signing this form, I consent to the following:

- Sharing information for purpose of treatment; this includes sharing this information with all members of my treatment team, both within and outside of this office (examples: laboratory services, radiology, primary care physicians, hospitals, etc…);
- Sharing information for purposes of payment: includes as necessary information to process insurance claims generated in the course of examination or treatment. This includes both governmental payers and non-governmental payers and includes any representatives appointed by the insurance carriers for purposes of benefits determination, utilization review and billing; I also consent to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.
- Sharing information for purposes of operations; this includes all ongoing operations of this office including, but not limited to, credentialing, peer review, accreditation and compliance with federal and state laws.

My consent is freely given. I understand that I may revoke this assignment and consent at any time if that revocation is in writing, but any disclosures given in reliance of this prior consent will be permissible.

I have read and understand the assignment of benefits form and I agree to be bound by its terms.

_____
Print Patient Name

_____ _____
Signature of Patient/ Responsible Party if Minor Date

_____ _____
Witness Date

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Office Policy and Patient Responsibility

Thank you for choosing Abilene Allergy for your Allergy, Asthma, Immunology, and ENT needs. It is our goal to make your experience with us a positive one.

We have established some guidelines regarding financial responsibility, office policies and patient responsibilities.

We will file your insurance for you if we accept and are in network with your plan.

- When making an appointment with our office, it is your responsibility to confirm with your insurance company that we are in network.
- It is your responsibility to understand your insurance plan coverage. If you do not understand or have questions about your plan or coverage you may wish to contact them using the number on the back of your insurance card. Our office never guarantees that your insurance will pay for all services. We will make every attempt to obtain benefits prior to treatment being given. Will file your claim for you. However, if for any reason your claim is denied, you are responsible for the amount due on your account.

Referrals

- With some insurance plans, you may be required to see a Primary Care Physician (PCP) in order to see a specialist. If your plan requires authorization by a PCP, you must obtain a referral prior to scheduling. If your plan requires a referral and you or your PCP does not provide one by the time of your appointment, please be prepared to be rescheduled.

Copayments, Deductibles and Coinsurance

- If you have a set copay that is due at each visit, be prepared to pay the same day. If you have an associated deductible that has not been met or a coinsurance and no set copay, we do require your insurance allowable at the time of your appointment. This varies depending on your plan.

Check-In

- Your time is important to us. The first step in keeping your appointment on time is being prepared. This includes filling out all required paperwork prior to your first appointment and completing your patient portal ahead of time. It is extremely important that you provide us with any requested information to avoid any delays in creating your chart/account at your first appointment. <u>You must arrive 30 minutes prior to your appointment at your first visit. If you do not you could be rescheduled.</u> If you did not receive the invite to the patient portal, are having trouble logging in or navigating the patient portal, please call our office and we will be happy to help.

A Valid Picture ID/Driver's License and your Insurance Card

- <u>A picture ID and your insurance card are required at the time of service. We are unable to verify identity, confirm insurance coverage and file your claim appropriately without this information.</u>
- It is your responsibility to notify us of any changes to your address, phone number or insurance plan. Please also provide us with your new insurance card as they are issued. Failure to keep us up to date may cause your insurance claim to be rejected, thus making the charges your responsibility.

Prescription Refill Policy

- Our office requires that you be seen on a routine basis in order to maintain any prescriptions given by our provider. These prescriptions have been written to allow the maximum number of refills the provider feels comfortable giving without having to assess your condition, review test results or assess compliance. Please keep your follow up appointments and plan ahead to avoid being without your medication.

Policy on Electronic Devices

- In observance of the confidentiality rights of other patients and out of respect for the privacy of our employees and provider, please either turn off your cellular device or place them on silent.

Missed Appointments, Late Cancellations, Late Arrival and Non-Compliance

- Please keep in mind that appointments are time slots reserved specifically for you. Please give at least a 4-hour advance notice if you are unable to keep your scheduled appointment. For your convenience we offer appointment reminder calls and texts at least 48 hours prior to your scheduled appointment. It is ultimately your responsibility to keep track of your scheduled appointments.
- We do our best to stay on schedule. When a patient arrives late that disrupts the schedule for the rest of the day and makes it impossible to stay on time. If you arrive more than 15 minutes past your scheduled appointment time once you are established without making an effort to reach out to the clinic, you will be rescheduled so that other patients are not inconvenienced.
- You won't be rushed when you see the doctor and we strive to give every patient the same attention.
- Patients with multiple no shows or cancellations are at risk of being discharged and each are assessed on a case-by-case basis.
- Please note that non-compliance with our office policy and patient responsibilities could result in dismissal from our practice.

Appropriate Behavior in office and with our office staff

- To keep our office a safe and inviting environment for our patients, physicians and staff, we expect appropriate behavior while in office and over the phone by all patients, parties and anyone calling on their behalf. We will not tolerate any cursing, name calling, yelling/shouting or threats toward our patients or staff. This type of behavior is grounds for immediate dismissal from our practice.

Items that are required for your visit

- **Insurance Cards –** If you have health insurance, we will need to see it and take a copy or scan it into your chart during your visit.
- Written referral from your Primary Care Physician **if required** by your insurance plan**.**
- Copay or Deductible that is collected at the time of visit.
- Any and all completed paperwork
- Driver's License or Photo ID

_____

Print Patient Name

_____ _____

Signature of Patient/ Responsible Party if Minor Date

_____ _____

Witness Date