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AAIC FINANCIAL POLICY

Welcome to the Allergy, Asthma & Immunology Center, SC (AAIC). With the information provided below, we hope to answer any questions you might have regarding insurance coverage, out-of-pocket expenses, referral obligations, etc. Of course you may have individual questions regarding insurance benefits, and we urge you to **contact your insurance carrier for more information**. Should you need further information, our billing staff will be happy to assist you.

The AAIC participates with the following insurance plans:

Aetna	HealthLink
BC/BS IL	Medicare-Illinois
BC/BS MO	Medicare-Missouri
Blue Choice	Mercy and Mercy Premier Plus
Cigna	Private Healthcare Systems (PHCS)
First Health-CCN	Tricare Prime / Standard
GHP/Advantra	Unicare
Health Alliance	United Healthcare

Although we participate with the above insurance companies, many health insurance policies vary (even within the same carrier) and may limit coverage or access to our services.

YOU MUST call your carrier to verify that your **individual insurance plan** will cover your care at our facility. Any uncovered services rendered will be billed directly to the patient or guarantor.

Plans may require a **consultation request** from your PCP. Please discuss this with your PCP and insurance company prior to scheduling your appointment with us. This request must be in our records prior to scheduling your appointment.

If you have no insurance coverage for the scheduled service, or if we do not participate with your insurance, your account will be listed as "self-pay." **You will be required to make payment in full at the time of service and submit your own claims for reimbursement**. Should you want an estimate of charges prior to your visit, our billing department will be able to provide this. Exact charges for consultations & office visits cannot be calculated until the physician has determined the level of service. At the conclusion of your visit you will receive a detailed receipt of all charges and payments. If you have a commercial insurance that is not listed above, please check with our Business Office.

If you have Medicare primary and a secondary insurance from the list above, our billing staff will submit claims for you. A statement of all transactions and any patient balance will be sent to you on a monthly basis.

If you have dual private insurance (primary and secondary) from the list above, copayment is expected at the time of service. Our billing staff will submit claims to the primary insurance. We only submit claims to your secondary insurance for balances greater than $10.00. Payment for balances of less than $10.00 is expected at the time of notification. If you desire reimbursement from your secondary insurance in these cases, you will be required to submit your own claim to your secondary insurances. A statement of all transactions and any patient balance will be sent to you on a monthly basis.

You will be asked to present your insurance card at every visit. *We ask that you notify us of any* change in insurance type, policy number or primary care physician. In some cases these changes will necessitate a new request for consultation or referral. Our billing staff will be happy to address any questions regarding change in coverage, benefits and referral requirements. Please note however, that failure to notify us of changes may result in your claim being denied. You will be responsible for payment of services denied by your insurance. We reserve the right to forward all delinquent claims to a designated collection agency. Any and all additional fees incurred as a result of this action will be the responsibility of the patient or guarantor.

Uncovered services: We at the AAIC provide world-class care for our patients. Accordingly, some of the services we provide have been deemed "uncovered" by Medicare (CMS) and many private insurance carriers. Accordingly, since these charges are often not covered by insurance, **we directly bill these services to our patients**. Such "uncovered" services include (but are not limited to) **telephone correspondence(s) / school forms / encounter(s) of any nature, telephone prescription or refill requests and internet/web-based correspondence(s) and encounter(s).**

PLEASE READ CAREFULLY

1. **Standard insurance co-payments are required at the time of service. A billing fee of $15.00 will be assessed if co-payments cannot be made at the time of service.**

2. **There is a $35 fee for returned checks.**

3. **There is a $250 fee for MISSED new patient appointments or for new patient appointments CANCELLED less than 24 hours prior to the scheduled appointment.**

4. **There is $50 fee for missed follow-up appointments.**

5. **There is a $15 fee for filling out school forms.**

6. **To secure payment for our services, we require that your credit card information be kept on file for uncovered expenses or fees due to missed or canceled appointments with less than 24 hours notice, unpaid balances, uncovered expenses, services or fees.**

7. **All balances are due at the time services are rendered.**

Payment Terms Acknowledgement and Credit Card Holding Information

I, _____, have read and understand the above and agree to the
(Print Name / Guardian Name)

terms and conditions stated above. Furthermore, I authorize the AAIC to charge my credit card for any of the aforementioned fees, provided uncovered services or charges in excess of what my insurance covers (e.g. coinsurance), if applicable. If approved by our billing staff, balances carried, will accrue a service fee each calendar month per the following schedule: $0-500, $10; $501-1000, $20; $1001-1500, $30, and so on. In these situations, automatic, monthly payments will be required and balances must be paid within 3 calendar months. Failure to pay your bill will require us to send your account to collections. In the event your account is submitted to collections, you will be responsible for any and all collection agency fees.

Credit Card: Visa / MasterCard / Discover

Credit Card Number: _____

Expiration Date: _____

CVV (3 or 4 digit code) / Zip code where CC bill is delivered: _____/_____

Insurance Payment and Medical Record/Benefits Investigation Authorization

I request payment of authorized benefits be made either to me or on my behalf to

_____ (provider name), for any services furnished me by that physician/provider. I authorize any holder of medical information about me to release to Allergy, Asthma & Immunology Center, SC any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____

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