



# The Asthma & Allergy Center

3503 Samson Way #108 • Bellevue, NE 68123-4303 PHONE (402) 592-2055 FAX (402) 592-2419 [www.asthmaandallergycenter.com](http://www.asthmaandallergycenter.com)

## Payment Policy

Thank you for choosing The Asthma & Allergy Center. We are dedicated to providing the finest healthcare for asthma and allergic diseases in children and adults.

**Insurance Coverage:** You, the patient, are ultimately responsible for your own bill and a clear understanding of your insurance policy. If you have healthcare coverage please provide our office with complete and accurate information regarding your insurance. We will need the primary policyholder's date of birth in order to file your claim. If you cannot provide this information, you will be responsible for payment of all services rendered at your visit and you will need to file for insurance benefits on your own. Understanding the terms of your insurance includes but is not limited to: knowing what services are covered (allergy skin test, breathing tests, etc.), if we are in-network, your deductible, copayment, coinsurance, obtaining required referrals.

For the protection of our patients, in order to reduce medical identity theft, all patients are required to present a valid insurance card and driver's license at the time of service. If a driver's license is not available a valid photo ID must be presented.

We will file primary and secondary claims for you. We must have the explanation of benefits from the primary insurance claim in order to file secondary claims.

We collect all copays, coinsurance, deductibles and remaining balances when you check in at the front desk. By signing this you understand that you are ultimately responsible for all charges, copays, deductibles, coinsurance and remaining balances not paid or covered by your insurance.

**Self-Pay Patients:** Patients without health insurance coverage are expected to pay their bill in full at time of service. For your convenience, we accept cash, check and Visa, MasterCard or Discover.

**Nonparticipating Insurance Plans:** If The Asthma & Allergy Center does not have an existing contract with your insurance plan, you will be responsible for the full amount billed.

**Billing Separate Entity:** If your employer or other entity is paying for your medical services, you will be liable should the employer or other entity not reimburse Asthma & Allergy Center for the services rendered.

**New vs Established Patient:** Per AMA coding guidelines, a new patient is one who has not received any professional services from us within the last three (3) years.

**Office Visits/Procedures/Vaccines:** Our office will verify your insurance benefits, to determine how much is your responsibility prior to your appointment, procedure and/or extract being made. We will collect all copays, coinsurance, deductibles and remaining balances when you check in at the front desk and prior to making your extract.

**Shipping:** You, the patient, is ultimately responsible for all charges related to shipping or transporting vials or other items, including replacement of missing or damaged vials or items.

**Referrals:** If your insurance policy requires a referral, you are responsible to see that a referral is obtained and provide that referral to our office.

**Fees and Services Provided:** Each patient's insurance coverage is different. If you have a concern regarding our fees, it is your responsibility to ask prior to the service being performed. There will be a charge for the provider's evaluation and separate charge for any service/procedure performed. Charges for services provided are subject to change without notice.

**Refunds:** We will make best efforts to refund overpayments to the appropriate party. Patient refunds will not be processed until all active or past due accounts for patients or dependents are paid in full. Unless you specifically request a refund of any credit balance, all refund and overpayments less than \$50 will be applied as a credit on the patient's account.

**Past Due Accounts:** If your balance remains unpaid your account may be referred to a collection agency. If your account is at a collection status, the balance will need to be paid in full prior to your next visit.

**Minor Patients:** All patients below 19 years old must be accompanied by a parent or guardian to receive treatment. Minors may receive allergy shots without the parent's presence if the parent/guardian has given signed permission.

**Child Custody:** The parent or legal guardian that presents the minor for care and authorizes treatment will be the one who receives the bill for services provided and is responsible to see that the balance is paid.

**Appointments:** We require 24 hours (1 business day) notice to cancel or reschedule office visits. This allows us to fill our schedule with another patient. If you cannot keep your appointment and do not provide sufficient notice, you may be charged a \$40 fee. Fees must be paid before your next appointment. Arriving late for an appointment may require you to reschedule.

**NSF Fee:** If your bank returns your check payment to us due to insufficient funds in your account, we will charge you an NSF fee of \$35.

**Medical Records Fee:** We transfer medical records to other physicians at no charge. A charge based on the Nebraska Statute 71-8404 will be applied for all other requests, including personal use. By signing this you understand that you are ultimately responsible for all charges, copays, deductibles, coinsurance and remaining balances not paid or covered by your insurance

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**Printed Name of Patient:** \_\_\_\_\_

**Printed Name of Parent/Guardian, if patient is under 19 Relationship to patient:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient (or Parent/Guardian) :**

\_\_\_\_\_  
**Date:**

12-23-2020