

## Sonoran Allergy & Asthma Center

### Importance of patient awareness regarding insurance benefits:

Dr. Ispas realizes how important insurance benefits are. **We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of benefits, deductibles, frequencies and restrictions.** Please be informed that insurance is a contract between you and your insurance company. Our role is to assist you with filing your claims. Dr. Ispas is providing the highest quality of care for you and your family regardless of insurance benefits and deductibles. Please be aware that your insurance may have a yearly deductible. You will be responsible for payment of half of the allowable balance of your remaining deductible during your first visit. Your responsibility also extends to include the copay for specialist's services, if applicable. Your insurance mails a copy of the Explanation of Benefits (EOBs) to you. Please pay attention to these statements. Please provide us with a copy of your insurance card/s at the time of your first visit or at the time of insurance coverage changes. It is your responsibility to provide us with any future changes in your insurance.

\_\_\_\_\_ (Initials) **I understand the above information.**

### Financial Policy

In order to provide you with the highest quality medical care on a sound business basis, we will provide an estimate of fees to you, if requested. Patient, parent and/or guardian are responsible for the patient portion. This is not your insurance company's responsibility. **We will file all necessary claims to your insurance as a courtesy to you.** It is your responsibility to contact your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and interest will be applied to your account at the rate of 1.5% of the unpaid balance per month.

#### **ASSIGNMENT OF INSURANCE BENEFITS:**

Patients with insurances please read and sign below:

I hereby assign all medical benefits related to services from Sonoran Allergy and Asthma Center, PC, to include medical benefits to which I am entitled, private insurance, and any other health plans, to Sonoran Allergy and Asthma Center, PC. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

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

**MEDICARE PATIENTS:** I request payment of authorized Medicare benefits be made on my behalf to Sonoran Allergy & Asthma Center, PC for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**Patient's Name: (Please Print)** \_\_\_\_\_ **Patient's Signature** \_\_\_\_\_

**Financial options**  
**Check those that apply:**

1. \_\_\_\_ Cash or check on date of service
2. \_\_\_\_ Major Credit Card - Master Card and Visa preferred. American Express and Discovery also accepted.
3. \_\_\_\_ Extended payment plan- Based on credit approval for a maximum of 6 months for larger balances only.

It is your responsibility to complete recommended follow up appointments as directed by Dr. Ispas. If the follow up appointments are missed, adverse results could affect your health.

\_\_\_\_\_ **(Initials) I understand the above information.**

**Appointment Commitment**

We appreciate you choosing us to meet your medical needs. We take this responsibility seriously and have qualified team members to accommodate you during your reserved appointment time.

If circumstances occur and it is necessary to change your scheduled appointment, we request that you give us at least 24 hour notice. A broken appointment, one in which a patient does not call or show up, is unacceptable. If you have scheduled an appointment and do not show up or call, it may be necessary for you to come into the office personally and schedule any future appointments.

There may be a \$45.00 fee assessed for the missed appointment.

\_\_\_\_\_ **(Initials) I understand the above information.**

I understand and agree to the aforementioned, and I agree to pay any/all remaining balance on my account.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_

**I ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF SONORAN ALLERGY & ASTHMA CENTER'S NOTICE OF PRIVACY PRACTICES.**

**PATIENT NAME:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_  
**RELATIONSHIP TO PATIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_