



Canton Asthma & Allergy
P E D I A T R I C & A D U L T C A R E

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734-394-2661, FAX: 734-394-2666

FINANCIAL POLICY

Patient Name (PRINTED)

Date of Birth

Chart Number

Thank you for choosing the physicians at our practice. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office personnel. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the doctor.

The patient's portion of payment, as well as any past due balances, is due at the time services are rendered unless prior arrangements have been made. We accept cash, personal checks, Master Card, Visa Discover credit cards, and Pay Pal online. If you wish to be billed, there will be a \$10 charge added to your office visit charge(s).

We participate with most major insurance companies and plans. Examples include but are not limited to Blue Cross/Blue Shield, traditional and PPO, Medicare, Medicare Advantage, Medicare Plus Blue, HAP HMO and PPO, Priority Health and Preferred Choices. Please check with us if your plan is not listed. **It is YOUR responsibility to check which services are covered under your Insurance Plan;** however, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the Insurance Company. Our relationship is with YOU, not with your insurance carrier.
2. All charges are YOUR responsibility whether your insurance company pays or not.
3. Fees for service, co-payments and unpaid deductibles are due at the time of service. See paragraph 2 above.
4. If the Insurance Company does not pay our balance within 60 days, we may ask you to contact them to request prompt payment. Please inform our office of their response.
5. Billed balances over 30 days will be charged a **1.5% rebilling fee.**
Billed balances over 60 days will again be charge a **1.5% rebilling fee.**
6. Billed unpaid **balances over 90 days are subject to a \$30 Collection** fee and will be sent to small claims court, an attorney, and/or Collection Agency. *
7. Returned checks are subject to a **\$30 collection charge;** we will notify you by mail. If your outstanding balance is not paid within 10 days, it may be subject to formal collection action as detailed above.
8. Patients who miss their scheduled appointments will be responsible for a **"NO SHOW" fee of \$25** if they have failed to contact our office at least 24 hours in advance for missed appointments.

* We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS: I authorize release of any information required to act on any Insurance Claim and permit photographic, electronic or other facsimile reproduction of this authorization to be used in place of original assignment. I hereby assign to Canton Asthma and Allergy physicians the medical benefits I am entitled from my insurance company and/or Medicare. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I understand that I am financially responsible for all charges incurred as described above. I, the undersigned, understand and agree to be bound by this Financial Policy.

Patient's Signature (or Parent/Guardian if Patient is a Minor)

Date

Signatory's Printed Name

Relationship to Patient

Authorized Witness (Canton Asthma & Allergy)

Date