ALLERGY & ASTHMA CONSULTANTS
OF CENTRAL FLORIDA

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ADDITIONAL OFFICES: Oviedo • Hunters Creek • Waterford Lakes • Orange City

Patient Financial Policy

Thank you for choosing Allergy & Asthma Consultants of Central Florida (AACCF). We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Your signature below indicates that you have read, understand, and agree that:

Co-payments and/or deductible are due at the time service is rendered unless prior arrangements have been made in advance. For your convenience we accept cash, checks, Visa, Mastercard, Discover, and American Express. There will be a $25 charge for all checks returned for non-sufficient funds, etc.

Your health insurance plan is a contract between you, your employer and the insurance company. AACCF has made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment and any additional percentage and/or deductible due. It is the patient's responsibility to assure that we are a participating provider on your plan. AACCF will make every attempt to verify your insurance benefits prior to your initial visit. When your insurance makes payment to AACCF and there is a remaining balance due, payment is expected upon receipt of our statement. If you have any questions please do not hesitate to contact our insurance office.

If we have not received payment from your insurance in 60 days, we will look to you for payment in full. It is your responsibility to be aware of your coverage, rights, benefits, and responsibilities per your insurance plan.

If your insurance requires a "referral" from your primary care physician (PCP), you will need to contact your PCP for the referral. This is the patient's responsibility NOT the responsibility of this office. *Treatment provided by our office without the required referral will serve as your consent to treatments not covered by insurance and will be payable upon receipt of services.*

If you have insurance coverage with a plan for which we do not have a prior agreement, the charges for your care and treatment are due at the time of service.

In the event that your health plan determines a service to be "not covered", you will be responsible for the balance for service performed. Payment is due upon receipt of a statement from our office.

Patients with uncollected balances over 180 days will be referred to our collection agency and discharged from our practice. Please help us protect your credit by promptly paying any balance due. Please communicate any financial difficulties, etc. with our billing office.

Minor Patients:

A parent or legal guardian must accompany patients who are minors. The accompanying adult is responsible for payment of the account, according to the policy outlined in this financial policy.

Completed Forms:

There is a charge of $25.00 prepaid for any form or letter that patients request to be completed, with the exception of school medication authorizations.

Authorization:

I hereby authorize Allergy & Asthma Consultants of Central Florida to (1) release any information necessary to insurance carriers regarding my (my child's) illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, and deductibles, are my responsibility and will be paid in full upon receipt of statement.

It is my understanding that the portion I pay at the time of service is an estimate only based on the information Allergy & Asthma Consultants has received from my insurance company, and understand that if there is any balance due after they process my claim that I am financially responsible for that amount.

I authorize my insurance benefits be paid directly to Allergy & Asthma Consultants of Central Florida.

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Printed Name of the Patient

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Signature of Patient or Responsible Party if a Minor Date