FINANCIAL POLICY

Method of Payment
We accept cash, check, Care Credit, and most major credit cards for your convenience. Returned NSF checks are subject to a $25 NSF fee and Company will no longer accept checks from patients who have written a returned NSF check. These patients will be asked to pay in an accepted alternative means such as money order, credit card or cash for all future transactions.

New Patients and Referrals
Each patient's primary care physician is responsible for coordinating his/her patients' health care. If you are seen without a referral, depending on your plan type, you may be responsible for payment for all services rendered. We encourage patients to know the requirements of their specific health plan. For new patients without insurance, payment in full at the time of service is required. For all patients with insurance, we require copays to be paid at the time of service. For insurance plans with high deductibles that have not yet been met, we require a deposit to be paid at the time services are rendered and then billed for the difference. The deposit amount will vary dependent upon the services being rendered at time of service and the amount of deductible needing to be met at time of service.

Usual & Customary Rate
Our clinic is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. You are responsible for paying any balance in full, regardless of your insurance company's determination of usual and customary rates.

Billing for Insurance Accounts
Verification of benefits is not a guarantee of payment or eligibility. If your insurance company pays differently for any reason than estimated, you agree that you are responsible to pay any remaining balance within 30 days of notification by your insurance company. If after 60 days from filing your claim we have not received payment from your insurance carrier, we ask you to pay the remaining balance on your account.

Appointment Cancellations and Electronic Communication
We require a 24-hour notice of change of appointment or cancellation. Failure to comply may incur a $50.00 cancellation fee. We appreciate you as a patient, and cooperation in complying with this policy will assist us in providing the best care possible to all of our patients.

Billing Communication
There are occasions when one of our Billing Department staff members will need to verbally contact patients regarding their account. On the chance we are unable to reachyou and get a voicemail, we ask that you check the appropriate box where you prefer to be contacted, including the number to call. This will allow us to leave more detailed information in our

message to you. Please note this is only an authorization to specify what information we are allowed to leave on your voicemail if you do not answer when we call. *(see next page)*

I authorize the following and I understand I can opt out at any time by submitting a written request:

 CAAC Billing Department Representative is authorized to leave a detailed voice message on my home phone at: _____

 CAAC Billing Department Representative is authorized to leave a detailed voice message on my cell phone at: _____

Patient Name (please print): _____ Date: _____

Patient Signature: _____

Guardian Signature: _____ Date: _____

Our goal is helping you understand your coverage. Verification of benefits is not a guarantee of payment. Please be advised, you are ultimately responsible for payment. You are responsible to notify Columbia Asthma and Allergy of any changes to your insurance, address, or payment plan. Please do not hesitate to ask about any of our policies.