The Center for
ALLERGY & SINUS

Allergy Financial Policy

In order to accommodate the needs and requests of as many patients as possible, Center for Allergy & Sinus is contracted with numerous insurance companies. We are pleased to be able to provide this service to you. Despite our best efforts however, it is not always possible for our staff to keep track of every requirement of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon what type of contract you are under.

If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and, for instance, your insurance coverage is not in effect on that day, your insurance carrier will probably deny payment for services received. Possible reasons your insurance may deny payment include:

- No referral number for visit
- Number of visits exceeds policy limitations
- Service or number of services within the period of time
- Injection or amount of injections
- Any procedures testing or endoscopies
- Office visits unless it was needed due to an emergency
- Same services by more than one physician during the same period
- More than one visit per day
- Extensive procedure
- Other _____

Also note that your personalized allergen extract will be prepared prior to your initiation of treatment after consent for treatment has been given. You will be billed directly, not through insurance, for the extract even if, for any reason, you decide not to initiate the allergen immunotherapy program after the extract has been made.

Please remember that you, the patient, are ultimately responsible for payment on your account.

With your cooperation and help, you should be able to receive all of the insurance benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE. MY PHYSICIAN HAS NOTIFIED ME IT IS POSSIBLE MY INSURANCE WILL NOT PAY FOR THE SERVICES I WILL INCUR. I UNDERSTAND AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

_____ _____

Patient / Parent or Guardian Signature | Date Signed

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