Allergy & Asthma Center of East Orlando

Boyce A. Hornberger, MD, FAAAAI
Diplomate American Board of Allergy and Immunology

Financial and Insurance Policy

Thank you for choosing Allergy & Asthma Center of East Orlando as your provider. This office is committed to providing quality healthcare and service to all patients. To assist us in this mission, we request that you read and sign the following financial policy prior to services being rendered.

- **Insurance** We participate with most insurance programs, but **it is your responsibility as the policyholder to contact the insurance company to determine what your covered benefits are.** You should also know the labs and diagnostic centers that participate with your plan. It is impossible for us to keep track of all the individual requirements of the many various plans. Although we verify your coverage, **verification of benefits is not a guarantee of payment from your insurance company.** Your insurance company doesn't guarantee your benefits until the claim has been **filed.** As a courtesy to you, we will file all medical claims with your primary and secondary insurance. Please provide us with your current insurance card(s) and any authorization information you may have. Notify us immediately if there are changes in this information. If you have two insurances, we expect you to know which carrier is primary and secondary. It is the responsibility of the patient or responsible party to see that all charges are paid in full. **If your insurance has not paid within 60 days you will be responsible for the balance.** Your insurance company will send you an explanation of benefits that explains what they have paid to our office. If you do not agree with their payment, please contact the insurance company directly. **Copayments/Coinsurance and Deductibles** are to be paid at time of service. For coinsurance and deductibles, we will **estimate** the amount you owe. You will be responsible for the balance after your insurance company pays your claim. **Deductibles must be paid.** It is a legal contract between you and your insurance company. We are **required** to collect your deductible. Payments may be made by Visa, MasterCard, American Express, Discover, personal check or cash. There will be a **$25.00** service charge for any returned checks. Returned checks will not be redeposited. Balances for returned checks must be paid by cash, credit card or money order.
- **Referrals** If you are a new patient whose plan requires a referral for treatment, the first authorization from your PCP must be requested by you. After your first visit, our office, as a courtesy, will try to obtain the authorization; **however, if you do not have a current referral, it will be necessary to reschedule your appointment.** Ultimately, it is your responsibility to make sure our office has received authorization.
- **Missed Appointments** There is a **$35.00 fee** for scheduled appointments cancelled with **less than 24** hours notice or for failure to keep a scheduled appointment. *If you have two missed no show appointments you may be dismissed from our practice.* This charge is not covered by insurance and you will be responsible for payment. Every attempt is made to provide reminder calls for appointments scheduled in advance; this is a courtesy only and has no effect on fees for missed appointments.
- **Form Fees** Forms that you request to be filled out for FMLA, short/long term disability, and all other insurance forms will be subject to a completion fee. The current fee policy is available from the front desk staff. School medication forms are completed at no charge.
- **Minors** Caring for children is one of our highest priorities. In all situations, the parent who brings the child into the office is responsible for payment at the time of service. For unaccompanied minors, or minors accompanied by another adult, payment arrangements need to be made **in advance** and we must have parent's or guardian's written permission prior to treatment of a minor.
- **Finally**, we realize that temporary financial problems may affect timely payment of your account. However, it is expected that all guarantors make "good faith" efforts to pay balances. Accounts that are 45-90 days past due may be referred to a collection agency, unless payment arrangements have been made with our office. If an account is referred to a collection agency there will be a **$25.00** service fee added to the balance. If you have a financial hardship, please let us know so that we might set up payment arrangements with you. Please bring any concerns regarding balances on statements to our attention immediately. We are here to try to help you.

Financial Policy: I understand I will receive a statement for any balances that may be due to the physician as a result of the following: Co-insurance or copayments, annual deductible amounts, non-covered services, out of network charges, terminated coverage, exhausted benefits, no insurance coverage, failure to respond to insurance company correspondence or inquiries. I understand and agree that the balance on my statement will be paid in full to the physician within 30 days.

Insurance Assignment: I hereby authorize my insurance benefits to be paid directly to Allergy& Asthma Center of East Orlando. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. **For Medicare Patients only:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services.

*****TO BE SIGNED ELECTRONICALLY AT TIME OF APPOINTMENT**