Allergy and Asthma Associates
Financial Policy and Credit/Debit Card Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. *I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.*
2. *Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.*
3. *This practice may deny service or charge a service fee for failure to pay a co-pay or any outstanding balance at the time of service.*
4. *It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.*
5. *I agree to provide the above practice and/or its designated payment agent with my debit/credit card information.*
6. *I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be stored independently by a Payment Card Industry (PCI) service provider in order to maintain the security of my payment information.*
7. *If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.*
8. *I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.*
9. *In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.*
10. *I will not be provided with advance notice of payments authorized hereunder for transactions up to a maximum amount specified by me. I will be provided with a courtesy notification prior to processing any payment in excess of such amount. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.*
11. *I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file.*

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be canceled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

______________________________ ______________________________
Cardholder Name as it Appears on Card Patient Name (if different from Cardholder)

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Cardholder Billing Address City State Zip Code

______________________________ ______________________________
Phone Number Cardholder Email Address

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CARDHOLDER SIGNATURE DATE

Allergy and Asthma Associates
Credit Card on File Policy

Allergy and Asthma Associates has implemented a Credit Card on File program as a convenient method of paying for the portion of your services that your insurance policy requires you to pay such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure. This policy has been implemented to simplify and enhance your patient experience, and to simplify our business operations.

Q & A about Credit Card on File

How does this work? At patient registration we will ask you to sign a credit card on file agreement. As part of the agreement you will be able to set a maximum to be charged to your card. Charges that exceed this maximum require verbal authorization from the card holder prior to processing payments. At checkout, fees due at the time of service will be paid using the card on file unless you elect to pay by an alternative method.

What are the benefits to me? You can use your credit card on file to pay for copays, coinsurance, and deductibles at future visits. It will make checkout easier, faster, and more efficient.

What if I don't have a credit card? It is our policy that payment is due at the time of service. You may also keep your Health Savings Account (HSA) or Flex Spending Account (FSA) credit cards on file. If you do not have either of these types of cards, then you can use a debit or credit card. We accept Visa, Mastercard, American Express, and Discover.

How can I be assured that my credit card information will remain safe? We are under the strict rules and guidelines of Payment Card Industry (PCI) Compliance, and HIPAA Compliance to protect patient privacy and credit card information is considered protected health information. Our third party credit card processing vendor will store your information on a secure and encrypted site, which will enable us to run bank card transactions on our computer system. Our employees will not have access to your bank card.

Appointment and No Show/ Cancellation Policy

1. We attempt to accommodate patients' appointments by scheduling at their convenience. As a courtesy, we will remind you of your appointment by calling and/or texting/emailing you prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event that your mailbox is full or your line is busy our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients.

2. We request cancellations be done at least 24 hours prior to the scheduled visit. If you cancel less than 24 hours prior to your scheduled visit or are a no show, we reserve the right to charge a fee of $50.00. If you cancel the rescheduled visit, you will be charged another $50.00 fee. Please note that the $50.00 cancellation fee cannot be submitted to insurance and is the sole responsibility of the patient. Please make every effort to attend your scheduled visit.

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Patient (or patient representative) acknowledgement Date