PATIENT RESPONSIBILITY

You, the patient/guarantor, are responsible for notification of any change in:

1) **YOUR HMO AFFILIATION/PPO AFFILIATION**
2) **PLAN OR COPAY CHANGE WITHIN YOUR HMO/PPO**
3) **AUTHORIZATIONS IF REQUIRED**

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services, your health plan determines that the services you received are not medically necessary and/or not covered by your insurance plan, or you have chosen not to use your health plan coverage.

Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be considered a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled

If the patient is a minor, the parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. AASMG does not get involved in custodial, separation or financial disputes involving or relating to divorced or separated parents for a minor child(ren) to whom we provide service. The parent who signs the financial policy and registration form of the minor child(ren) will be the responsible party for payment of services rendered.

I UNDERSTAND THAT IF I AM NOT ELIGIBLE FOR SERVICES PROVIDED BY ALLERGY AND ASTHMA SPECIALISTS MEDICAL GROUP, I WILL BE HELD FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

PATIENT NAME:_______________________________________(PLEASE PRINT)

SIGNATURE OF PERSON
LEGALLY RESPONSIBLE:_____________________________DATE___________

Please note that there is a $25.00 charge if you fail to cancel at least 1 full day (24 hrs.) prior to your appointment.

CO-PAYS ARE DUE AT THE TIME OF SERVICE, WE DO NOT BILL FOR CO-PAYS.

**** As a courtesy to other patients and our staff, please refrain from wearing fragrances, i.e.: Perfume, Cologne, or Scented Lotions. ****