ALLERGY & CLINICAL IMMUNOLOGY MEDICAL GROUP

BERNARD D GELLER, M.D., PH.D.

FINANCIAL POLICY

Thank you for selecting our office for your medical care. Although our main concern is to give the proper and optimal care and treatments to restore your health, *please read the following financial policy to avoid any misunderstandings.*

The patient or guarantor is responsible for payment *at the time of service*. This means that co-pay's, co-insurances, deductibles and balances must be paid when the patient is seen.

______ **(Initial)**

PPO or Contracted Insurance Coverage: If you have coverage through an insurance company with whom we have a contract, we require a copy of your insurance card *and* photo identification, your mailing address and payment of your co-pay, coinsurance or deductible at the time of service. ***If you, or the patient, later be determined ineligible for the services rendered, you agree to comply with the demands for payment from the provider.*** Payment is due at the time of service if benefits are available or upon receipt of your statement. Charges may apply for telephone consultations and completion of forms.

Cancellation Policy: If you cannot keep your scheduled appointment, please call our office ***at least 24 hours*** in advance to reschedule. This allows us to offer other patients that appointment time. Failure to cancel appointments with at least 24 hours notice will result in a charge.

______ Initial

Photograph: Your photograph will be uploaded into our EMR system (Electronic Medical Records) for purposes of patient identification.

Returned Checks: A $25 charge will apply for any checks returned for insufficient funds after which only credit cards will be accepted as payment.

Laboratory Services: We may order lab work for you to be drawn at an outside lab. You may receive a separate bill from the lab. *Some insurance companies require you to use a specific lab.* Because there are over 1,000 insurance companies, we cannot keep up with the constantly changing rules for each one. For this reason, we expect you to be familiar with your own insurance companies' requirements, and, if for any reason they do not allow you to use the labs we contract with (Quest and LabCorp), it is your responsibility to make us aware of this. You may choose to pay for your own lab tests or go to the laboratory where your insurance requires you to go.

I have read the above information and agree that, regardless of my insurance status, *I am ultimately responsible for the balance on my account for services rendered.*
In the event that my insurance is billed, I authorize payment of medical benefits to be paid directly to Allergy & Clinical Immunology Medical Group or Bernard D. Geller, M.D. I authorize the release of any medical information necessary to process my claims. A fax or photocopy of this agreement shall be considered as effective as the original.
Disclosed non-covered medical services are the responsibility of the patient.

Patient Name______________________________
(Print)

Responsible party (if other than patient)______________________________
(Print)

Signature of responsible party______________________________ **Date**______________
(Sign)

Revised 1/2020