ALLERGY & CLINICAL IMMUNOLOGY MEDICAL GROUP
BERNARD D. GELLER, M.D., Ph.D.

If you have Medicare or PPO insurance, medical claims will be submitted to your insurance company. Once claims have been submitted to your insurance, you should receive an "EOB", explanation of benefits, regarding your charges. We collect at the time of service for all procedures that we are able to obtain benefit information on. Per your contract with your insurance company, patient portions are due at the time of service. We call and verify insurance benefits as a courtesy to our patients, however insurance companies do not guarantee benefit information and do sometimes quote us the wrong benefits. Because Insurance companies do quote us the wrong benefits and are often behind on updating deductible information, for co-insurances and deductible amounts, we offer our patients the option of leaving a credit card on file to charge the patients portion after insurance has processed the claim (copay's will still be collected at the time of service). If you do not want to leave a card on file, we will charge you the estimated patient portion (deductible and/or coinsurance amount) at the time of service.

I, (print name)_____ have read and understand the above mentioned policy and **agree to leave my credit card on file**. I authorize Allergy & Clinical Immunology Medical Group to charge my credit card for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete to the best of my knowledge.

Or

I, (print name)_____ **decline to leave my credit card on file**. I understand that I will need to pay my estimated portion of charges upfront (i.e.: co-insurance, copay, deductible amounts). Once claims have been processed and settled with my insurance company, I will be refunded if my account has any credit due. We call and verify insurance benefits as a courtesy to our patients, however insurance companies do not guarantee benefit information and do sometimes quote us the wrong benefits.

Date_____

Patient or Responsible Party Signature_____

Patient Name if different from above_____

1301 20th Street • Suite 220 • Santa Monica • CA 90404 Tel (310) 828-8534 • Fax (310) 453-8468
www.sneezewheeze.com

Credit card information for patient portion of claims

VISA MASTERCARD AMEX DISCOVER

Credit Card #_____

Expiration Date: _____

Billing Zip Code: _____

CVV:_____

Cardholder Name: _____

Signature:_____ Date:_____

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