



ASTHMA & ALLERGY OF IDAHO

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

- All patients must read and sign this financial policy before seeing the provider.
- Payment is due at the time of service.
- We accept Cash, Checks, Visa, MasterCard, American Express, Care Credit, and Discover cards.

Regarding Insurance

You, the patient or parent/guardian, are responsible for all services regardless of your insurance company's definition of medical necessity or covered services. The balance of your account is your responsibility whether your insurance company pays or not. In order to bill your insurance company, we require the following:

- Insurance Information
- Copy of your insurance card – front and back

Please notify our staff promptly if you have a change in your insurance. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our staff will be happy to assist you with questions you might have. All claims are submitted electronically daily. If your insurance company has not paid on services within 45 days, we ask that you contact them with regards to their processing.

Payment

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Comprehensive skin and Immunocap blood testing patients will be asked to pay 20% of the services if insured and their deductible is satisfied. If you are uninsured or your deductible is not satisfied, you will be expected to pay 50% at the time of service and the balance is to be paid within thirty days after the service. If you have a copay, we will accept that for your office visit charge only.

If your payment via check is returned from the bank as dishonored, a \$20 returned check fee will be applied to the patient account.

Immunotherapy

If you choose to start allergy shots, we require you to keep your account balance under \$500.00 and less than 90 days old.

Patients who are on allergy shots are required to maintain an account balance under \$500.00 and less than 90 days old.

Appointment No Show Policy

Please make sure to come to all scheduled appointments. If something comes up and you cannot make your appointment, please contact our office to cancel. After three no shows, we will not be able to schedule another appointment without the provider's approval.

Minor Patients

It Is our policy that an adult will accompany minor patients. The parent who accompanies the minor to our office is responsible for the charges incurred and billings to any other party.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this policy.

X _____
Signature of Patient or Responsible Party Patient Name Date