

## DILLEY ALLERGY AND ASTHMA SPECIALISTS

Dilley Allergy and Asthma Specialists, LLP is committed to providing you with the best possible medical care. If you have health insurance benefits for the treatment of allergies and asthma, we want to assist you in maximizing these benefits. We ask that you review and familiarize yourself with our office financial and payment policies.

1. Payment is due in full at the time services are rendered. If we are contracted with insurance company, we will file your insurance claims for you. However, any co-payments, coinsurances or deductibles are still due at the time of service. For your convenience we accept cash, checks, debit cards, Visa, MasterCard, American Express, Discover and Care Credit.
2. Returned checks are subject to a \$25.00 charge.
3. Past due accounts turned over to our collection agency will be assessed up to a 50% charge. This fee is a non-negotiable fee that you will be responsible to pay.

### BILLING OF ALLERGY VACCINE AND INJECTIONS

Because our allergy injection clinic is not in the same office as our billing department, payment for allergy serum and injections will not be required at the time you receive the service, unless you are seen for an office visit on the same day. Our financial policy is regards to allergy serum and injections is as follows:

1. Payment for allergy serum and injections is due in full upon receipt of statement. For your convenience we offer an "Easy Pay" credit card authorization form.
2. An interruption of allergy injections will occur if there is a balance older than 30 days on your account for allergy injections.
3. Allergy serum refills will be processed when past due balances for allergy serum are paid in full.
4. Allergy serum will be released to another location for allergy injections when past due balances for allergy serum are paid in full.

### PAYMENT PLANS

While payment is expected at the time services are rendered, we understand that some situations may require a payment agreement between Dilley Allergy and Asthma Specialists, LLP and yourself. Please contact our billing department at extension 212 before services are rendered, to establish a formal payment agreement.

### ABOUT YOUR INSURANCE

Your insurance contract is between you, your employer and the insurance company. Dilley Allergy and Asthma Specialists, LLP will provide you with the best medical care based on your allergy and asthma needs, not based on your insurance coverage. All charges that you incur are your responsibility from the date that the services are rendered. We encourage you to make yourself knowledgeable about your insurance policy and benefits. Also, it is the patient's responsibility to make sure our office has a valid referral on file if required by your insurance.

### INSURANCE CHANGES

**If you have a change in insurance coverage it is your responsibility to notify us of that change immediately.** We will need a copy of your new insurance card for your medical records. If a change goes unreported, there may be charges that remain unpaid due to filing limitations of the insurance company. In this situation, you will be responsible for payment of all charges. **AT THE BEGINNING OF A NEW YEAR MANY INSURANCE COMPANIES ARE CLOSED OR DO NOT HAVE BENEFITS AVAILABLE FOR THE NEW YEAR UNTIL A LATER DATE. IN THIS CASE, WE WILL USE PREVIOUS BENEFITS QUOTED AND COPAYS, DEDUCTIBLES, AND COVERAGE MAY CHANGE, HOWEVER, WE WILL DO OUR BEST TO GET THE MOST CURRENT BENEFIT INFORMATION. REMEMBER IF YOUR INSURANCE REQUIRES A REFERRAL AND DILLEY ALLERGY DOES NOT HAVE A VALID REFERRAL ON FILE, ALL CHARGES ARE PATIENT'S RESPONSIBILITY.**

### BILLING STAFF

Our staff is available to answer your questions in regards to your account during normal business hours. If your question is in regards to your insurance or filing of your insurance, please dial extension 255. If your question is in regards to your account balance, a past due amount or a formalized payment plan, please dial extension 212

**I have read and understand Dilley Allergy and Asthma Specialists, LLP financial policies**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Witness Signature