Allergy Diagnostic and Treatment Center • David K. Brown, MD
Christian D. Gonzoph, PA-C • Rebecca A. Rosenberger, PA-C • Kristine M. Cisko, PA-C
33 Overlook Road, Suite # 307, Summit, NJ 07901
Tel . (908) 522-9696/Fax: (908) 522-3070
www.dkb-allergy.com

Financial Policy

In an effort to provide the best allergy specialty care at the lowest possible cost to you, our financial policy is designed to clearly define your responsibility for payment and our role in assisting you with insurance reimbursement for services you receive. We participate in most insurance plans, and bill to primary and secondary insurances. If you have any questions about our participation, please contact your insurance company or call our office. **If we do not have a contractual agreement with your insurance company, payment for office services is due at the time services are rendered.** We accept cash, check and credit card payments.

Please be aware that **some insurance companies have a limit on their allergy benefit/coverage**. Also, not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You should verify your benefit/coverage **before** making an appointment.

We will gladly discuss proposed treatment and answer any questions relating to your insurance. You must realize, however, that--

1. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowances determined by each carrier. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

2. **For each month greater than 30 days that your outstanding bill remains unpaid, you will be assessed a 5% finance charge.**

3. If your insurance requires a co-pay for **specialist or allergy shots** as explained in your insurance information your co-pay will be collected **before** services are rendered. **There will be a $10.00 surcharge if the co-pay is not paid at the time of the visit.**

4. If your insurance is an HMO, you are responsible to supply this office with the referral and/or authorization forms **prior** to being examined. **Failure to do so may result in denial of coverage, the fees for which you will be held responsible.**

5. **You are responsible for informing us of any changes in your insurance plan or policy.** Failure to do so may result in denial of coverage, the fees for which you will be held responsible.

6. If you do not have the proper forms described in your insurance handbook, then you MUST reschedule or, if your plan offers "Out of Network" benefits, then you may be seen as an "Out of Network" patient which may result in a somewhat higher cost to you.

7. **No show appointments** will result in a $225.00 no-show fee for **new patients**, and a $50.00 no-show fee for **established patients**. **Cancellation with less than 24 hour notice will automatically result in a $50 no show fee.** Patients will not be able to reschedule their appointments until the no show fee is paid in full. **Returned checks** will be subject to additional collection fee of $25.00 or greater.

8. **For any forms completed by our office a $10 charge will be assessed.**

We will do our best in the filing of insurance claims, however, all charges are ultimately your responsibility.

I understand and agree to the Financial Policy of the Allergy Diagnostic and Treatment Center.

_____ _____
Signature of Patient (Guardian). Date

_____
Print Name of Patient

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from
Print Patient Name
the Allergy Diagnostic and Treatment Center, LLC.

X_____ **Date:** _____
Signature of Parent /Legal Guardian/Authorized Person

I wish to be contacted in the following manner (check all that apply).

Home: Phone: (_____) _____

- ❑ OK to leave message with detailed information
- ❑ Leave message with call back number only
- ❑ OK to fax home: (_____) _____
- ❑ OK to mail my home address

Work: Phone: (_____) _____

- ❑ OK to leave message with detailed information
- ❑ Leave message with call back number only
- ❑ OK to fax work (_____) _____
- ❑ OK to mail my work address

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that the Allergy Diagnostic & Treatment Center may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to such. In that case, the Allergy Diagnostic & Treatment Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to such. I designate the following persons listed below as persons involved in my health care or payment relating to such. For the purpose of ADTC making the limited disclosures described above. (I understand that I am not required to list anyone and that I may change this list at any time in writing.

Print Name of each designated person below:	Date of birth:

Staff Only:

In lieu of patient signature, I, _____, a staff member of the
Print Name of Staff Member

Allergy Diagnostic and Treatment Center, LLC, state that _____ has been given our current Notice of Privacy Practices.

Date: _____