OCEAN ALLERGY

ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

FINANCIAL POLICY

We are pleased you have chosen us as your providers. We appreciate your trust and our goal is to provide you and your family the highest quality of medical care.

Our practice is contracted with numerous insurance carriers. Policies can change and subscribers need to know their own plans benefits and financial responsibilities, such as deductibles, co-pays, and co-insurances.

Your insurance may require a **referral** from your Primary Care Physician to be seen by a specialist, this must be obtained at least 72 hours prior to your visit. Please check with your Primary Care Physician to confirm it has been issued. **We will not be able to see you without a referral and your appointment will need to be re-scheduled.**

Should you choose to be seen in our practice and we do not participate with your insurance plan, you are responsible for the full payment of you bill at the time of service. We will provide you with an itemized receipt so you may file for reimbursement.

Dependent Minors of Divorced Parents: We expect payment from the parent/guardian who accompanies the child to our office. We will not bill a non-custodial parent, even though this may be part of the divorce agreement. We will be pleased to provide a paid receipt for services rendered.

We reserve the right to charge for missed appointments or any appointments **not cancelled 24 hours prior to the scheduled appointment.**

Past due balances are expected to be paid in full before future appointments are made. You agree to reimburse the fees of any collection agency which may be based on a percentage at a maximum of 50% of the debt, and all costs and expenses including reasonable attorney fees we incur in such collection efforts.

Our office accepts **Cash, Check, Visa, Mastercard, and Discover** for your convenience.

I have read and understand the financial policy stated above and authorize payment of any insurance benefits for unpaid services to Ocean Allergy Partners LLC and understand that I am responsible for any balances or unpaid insurance claims and other fees as described. I authorize the release by Ocean Allergy Partners LLC of my medical information that is necessary to evaluate and pay my medical insurance claims.

Print Patient Name _____

Patient Signature_____ Date: _____

Patient Representative's Name _____ Relationship to patient_____

Patient Representative Signature _____