**THE ALLERGY & ASTHMA CENTERS OF CAPE COD**

## Acknowledgment of Financial Policy

Thank you for choosing The Allergy & Asthma Centers of Cape Cod (AACCC). We want all of our patients to have a good understanding of our practice's financial policies. Please review the following information and if you have any questions, don't hesitate to call our office. We accept cash, checks, and all major credit cards.

**Insurance**

- I understand that it is my responsibility to pay any portion of services not covered by my health insurance. I acknowledge that it is my responsibility to verify my insurance coverage prior to my appointment. AACCC may inquire as to my benefits and eligibility on my behalf. I understand that benefits quoted by my insurance to AACCC staff are NOT a guarantee of payment. I will be responsible for any remaining balance that is not covered by my carrier regardless of quoted benefits.
- I agree to provide The Allergy & Asthma Centers of Cape Cod all insurance information, including primary and secondary and to have my current insurance card(s) available at every visit. Additionally, a photo ID is required for new patient visits. I acknowledge that it is also my responsibility to notify the practice of any changes to my insurance coverage prior to my scheduled appointments. If I do not notify the practice of such change(s) in my coverage or the effective date of any new insurance, I acknowledge that I am responsible for any charges that are not covered.
- I am responsible for any co-payments, deductibles, co-insurance and non-covered service fees. Co-payments are due at the time service. The co-pay requirement cannot be waived. The parent/legal guardian bringing a child in for visits will be responsible for the co-pay. If an inquiry into my eligibility shows an unmet deductible and co-insurance, the practice will collect such at the time of my appointment.

**Referrals -** It is my responsibility to obtain any necessary referrals and to maintain referrals as my insurance requires. I understand that AACCC may choose not to provide me services if a current referral is not in place prior to my visit. I understand that I am responsible for any charges that my insurance company may not pay as a result of my failure to obtain the necessary referrals/preauthorizations.

**Payment –** All patient balances are due in full upon receipt of our summary statement each month, unless a formal payment plan is established with the practice. Any payments received on account will be applied to the oldest balance first. I understand that, if I have a balance due at the time of a scheduled appointment, payment will be due at the time of service unless a formal payment plan has been established with the practice.

**Missed Appointments –** Broken appointments negatively impact other patients on our wait list who could have been seen at the appointment time we reserved just for you. We ask that you please be considerate of this if you need to reschedule your appointment. To this end, our practice requests a minimum of one full business day's notice for cancellations. I understand that if I have a late cancel or missed appointment I may be charged a cancellation fee of $35.00. Excessive late cancellations may result in discharge from the practice.

**Returned Checks & Refunds-** I will be charged a $35.00 fee for any returned checks. Credits in amounts less than $10.00 will be retained on account to be credited toward future balances unless a refund is requested.

**Minor Patients -** If I am the parent or legal guardian of a minor patient I am responsible for payment of the account as outlined above. AACCC will not be involved in divorce disputes.

**I understand and agree to the above Financial Policy of The Allergy & Asthma Centers of Cape Cod.**

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| Patient (Responsible Party) Printed Name | Patient (Responsible Party) Signature | Date |