Allergy & Asthma Specialists of Michigan

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43417 Schoenherr Road
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Financial Policy

Thank you for choosing Allergy and Asthma Specialists of Michigan as your allergy and asthma provider. We are committed to building a successful physician-patient relationship with you and providing you with the best quality of care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. The following is a summary of our financial policies, an explanation of your responsibilities, and authorization to bill your insurance on behalf of the services provided.

- You are financially responsible for any services performed by our providers that are not covered by your insurance policy. Services may not be a benefit of your health care insurance plan. We suggest you contact your insurance company to determine if services rendered by our office are a covered benefit under your insurance policy. If you need assistance in obtaining this information we will be glad to help you.
- You are financially responsible for any copay, deductible, or coinsurance which is an amount determined by your specific insurance policy. Payments including copays, are due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express, and Discover. A fee of $25.00 will be charged for returned checks. Balances greater than 60 days will be subject to additional fees. We realize that temporary financial problems may affect the timely payment of your account. If such problems arise, we encourage you to contact our billing department immediately for assistance in management of your account.
- Your insurance is a contract between you and your insurance company. We will bill your primary insurance as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance as well as any change in name, address, or insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill.
- If your insurance company is not contracted with us, you will be responsible for payment in full. However, as a courtesy our billing office will file your initial insurance claim. If it is not paid in full after 30 days, you will be responsible.

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- If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.
- If your insurance plan requires that you obtain a referral form your Primary Care Provider (PCP) before visiting a specialist, YOU ARE RESPONSIBLE for obtaining the referral. Failure to obtain the referral may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if a proper referral is not obtained.
- Divorced parents: The parent/guardian who was granted primary custody is responsible for payment of copays & deductibles at registration. If a divorce decree states medical expenses are shared, the custodial parent/guardian will be billed for the full amount and is responsible for obtaining their own reimbursement of the shared expense from the non-custodial parent.
- Please understand that when you reserve an appointment with one of our providers, that we are making a commitment to your medical care and this prevents another patient from receiving care at that time. Please provide our office with a 24 hour notice for cancelled appointments. Failure of a cancellation less than 24 hours' notice may result in a $30.00 cancellation fee.

Patient/Responsible Party Statement

If my physician does not participate with my insurance company or my insurance company does not pay for services provided, I agree to be personally and fully responsible for payment. I also accept responsibility for any copayments and/or deductibles. I understand a statement of my charges and payment will be sent to my mailing address unless I otherwise indicate. I have read understand and agree to the above Financial Policy and signed this form prior to any services being rendered.

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Signature (Patient/Parent or Parental Guardian) Date

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Print Name of Patient/Parent or Parental Guardian