

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing *Allergy and Asthma Care of Wylie* as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. In order to do this, we require that the you please provide us with the most correct and updated information about the insurance. The patient will be responsible for any charges incurred if the information provided is not correct or updated. It is the patient’s responsibility to confirm whether we are in network with their insurance and the patient bears responsibility for payment.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service. For your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of Allergy and Asthma Care of Wylie. These charges may include (but are not limited to):
 - Charge for returned checks.
 - Charge for missed appointments without 24 hours advance notice
 - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
 - Charge for the copying and distribution of patient medical records.
 - Charge for extensive forms completion.
 - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize Allergy and Asthma Care of Wylie to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies and third party payers.
- By my signature below, I hereby authorize assignment of financial benefits directly to Allergy and Asthma Care of Wylie and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Printed Name of Patient (or parent/guardian if patient <18 years)

Signature of Patient (or parent/guardian if patient <18 years)

Date

Allergy and Asthma Care of Wylie

611 South Highway 78, Suite 102
Wylie, TX 75098

Dear Patient:

Phone: (972) 954-9826

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

- Payment by cash
- Payment by check
- Payment by credit card
- Automatic monthly billing to your Visa or MasterCard
- Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

Print your name here and sign below

x _____

Date: _____

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