*Warren Allergy & Asthma Care, PC  31730 Hoover, Suite A  Warren, MI 48093*

# Financial Policy

The following is a summary of our financial policies, an explanation of your responsibilities, and authorization to bill your insurance on your behalf for services provided to you.

- You are financially responsible for any service performed by our providers that are not covered by your insurance policy. Services may not be covered for several reasons including, but not limited to:
    a) The services provided may not be a benefit of your health insurance policy.
    b) You may have exhausted your benefit for the services provided.

- You are financially responsible for any co-pay or deductible which is an amount determined by your specific insurance policy.

- **In case of divorced parents, the parent bringing the child into the office is the financially responsible party.**

- You are expected to pay at the time services are rendered unless prior arrangements have been made.

- We suggest you contact your insurance company to know 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 must obtain a valid referral for services provided, if your insurance requires one.

**A fee of $15 will be charged for any returned checks.**
**A fee of $20 will be charged on any accounts that are sent to collections.**

## Lifetime Beneficiary Claim Authorization

I request that payment of authorized benefits form Medicare, Private Insurance and other health insurance plans be made on my behalf to Warren Allergy & Asthma Care, PC. I authorize any holder of medical information about me to release to my insurance company; Medicare or other insurance companies and its agents any information needed to determine these benefits payable to related services in accordance with the The Health Insurance Portability and Accountability Act (HIPAA).

## 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 co-payments and or deductibles. I understand a statement of my charges and payments will be sent to my mailing address unless I otherwise indicate. I have signed this form prior to any services rendered.

I have read and understand the above financial policy.

_____ _____
Signature (Patient/ Parent or Parental Guardian) Date

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PRINT Name of Patient /Parent or Parental Guardian