ALLERGIC DISEASE ASSOCIATES, PC, T/A THE ASTHMA CENTER

FINANCIAL POLICY

Welcome to The Asthma Center. We are committed to providing you with the best care possible. To support the achievement of this goal it is best if everyone is aware of our financial policy, which is an agreement between our practice, The Asthma Center, and the patient and/or guarantor. Your clear understanding of the financial policy agreement is important to our professional relationship.

The following is intended to clarify our financial rules and payment practices for the benefit of our patients. This financial policy is a legal arrangement between the Practice and its patients. By signing below, you, as our patient (the patient's legal representative, as applicable) agree to abide by its terms and requirements.

Please also note that information in this Policy is not intended to be interpreted as legal advice or as interpretation of the term of patient's insurance policy or benefit plan. Patients must refer any questions regarding medical services coverage, amount of coverage, co-payments, deductibles, out of pocket costs, mandates, claim adjudication, appeal, etc. to their carrier or legal counsel.

INSURANCE

At each visit, please bring identification (e.g., current driver's license or government issued ID) and a copy of your insurance card. Payment for services is due at the time services are rendered, except as outlined below. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered.

It is the responsibility of the patient to provide accurate and current insurance information. Inaccurate or untimely information given to our staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment. If the patient is a dependent, you are responsible for all charges even if you did not accompany the patient to our office for treatment.

NON-EMERGENCY APPOINTMENTS

Routine follow-up, allergy injections and the like may be rescheduled or cancelled if there are outstanding balances or if a co- payment is not made at time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer (if you are insured by a group benefit plan), and your insurance company. ***It is important for you to be an informed consumer who understands the specifics of your insurance policy.***

BILLING

Patients are required to have a valid credit card on file with us. Please refer to our Credit Card Authorization Form on the last page of this policy. Patients that do not have a valid credit card on file will not be seen.

We will provide you with an itemized statement, monthly, as well as when requested. We accept cash, checks, MasterCard, Visa, Discover, American Express and offer online payments through our payment processor. **Patient-responsibility balances are due within 30 days of the statement date, unless prior arrangements have been made with the billing department**. A $20 billing fee will be charged to you if your co-payment is not made at the time of service. A $50 fee will be charged for all returned checks and your account will be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared. Any patient balances that have not been paid within 30 days of the last billing will incur a late fee of $50.00. Individuals with balances not paid in full within 90 days of the initial statement date will receive a final written notice that will inform you that your balance will be forwarded to a collection agency. An additional collection fee of $50 will be charged on all collection accounts. Please note these fees are not covered by your insurance company. If your account is forwarded to a collection agency, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care. We will attempt to collect any unpaid balance to the extent we are allowed by law, regardless of whether you are still a patient. Also, please note that you are responsible for all charges incurred for dependent patients even if you are not the

guarantor or other responsible person for such charges under the applicable insurance policy or otherwise. Additionally, if the patient is a dependent, you are financially responsible for all charges even if you did not accompany the patient to our office for treatment.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department (215-569-1111, option 2) promptly for payment arrangements and assistance in the management of your account

Should your account balance become uncollectible due to bankruptcy, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care.

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY (In-network insurance)

You are responsible for paying all co-payments at the time of service and are subject to a $20 billing fee if not paid at time of service. Annual deductibles, coinsurances, and any unpaid balance owed to us will be billed to you in accordance with the explanation of benefits (EOB) from your insurance. As a courtesy to you, all services performed in our office will be submitted to your insurance on your behalf.

All in-network insurance carriers have a fee schedule (allowable charge amount) according to which they will reimburse The Asthma Center. However, the practice's allowable charge amount may be higher than what the insurance company reimburses, or it may not be a covered service. Therefore, any balances not paid by your insurance become the responsibility of the patient/guarantor consistent with your Explanation of Benefits (EOB).

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY (Out of network insurance)

If we do not participate with your insurance plan, we are not able to bill your insurance and we cannot accept payment from them for our services. If we do not participate with your insurance, we can still provide you with medical care, however you will be responsible for full payment of services at the time of your visit(s). Patients will be responsible for contacting their insurance to ensure they have out of network benefits and to understand what their out of network benefits cover and the out-of-pocket costs. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement of your out-of- pocket cost. Not all services provided by The Asthma Center are covered benefits in all contracts. Patients are financially responsible for all services which may be more than the allowable amount of your insurance plan. Payment for services is due at the time of service. A $20 billing fee will be added to balances not paid at the time of service.

MEDICARE

Patients are responsible for the annual deductible and/or 20% of the Medicare allowable amount for all covered services. (Medicare supplemental insurance may cover this amount.)

NON-COVERED SERVICES AND SELF PAY

If our services are not covered by your insurance plan or if you have no insurance, you agree you are financially responsible for all charges. If the patient is a dependent, you are financially responsible for all charges even if you did not accompany the patient to our office for evaluation and/or treatment.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Missed appointments represent a cost and inconvenience to us and to other patients who could have been seen in the time set aside for you. For cancellations, 48 hours notice prior to the appointment time is required. For new patients, failure to provide 48 hours notice of cancellation or failure to come to your appointment will result in a $150.00 fee.

For follow-up appointments, failure to provide 48 hours notice of cancellation or failure to come to your appointment will result in a $75.00 fee. For special testing (including allergy testing, food or drug challenges, methacholine or exercise challenges, and desensitization), a missed appointment or cancellation with less than 72 hours notice may result in a fee of $250-$450 based on the scheduled service (as indicated on the testing information sheet which you

received when scheduling the test). Notice of cancellation must be provided by direct phone contact (speaking with a member of our staff during business hours). Notice will NOT be accepted by any other means (such as voicemail, email, fax, or text messaging). **Your credit card on file will be charged accordingly for missed appointments.** Please note these fees are not covered by your insurance company.

We reserve the right to discharge patients who miss multiple appointments, fail to give 48-72 hours prior notice of cancellation, repeatedly cancel appointments or repeatedly do not show up for scheduled appointments.

FORMS AND FEES

There is a $20-$30 fee for the review and completion of all forms. The fee depends on the type of form to be completed. (i.e. school/camp forms, disability, FMLA, etc.) There is a charge for copies and release of medical records.

REFERRALS

If your insurance plan requires a referral for you to see a specialist, for office visits, procedures or allergy injections, you are responsible for obtaining and keeping track of all referrals. You will have to reschedule your appointment if you do not have a valid referral at time of services. If a patient chooses to be seen without a referral form at the time of service, the patient will be responsible for payment in full at the time of service. We will NOT accept any referrals for services after services are rendered.

FOR MEDICARE PATIENTS ONLY

MEDICARE ASSIGNMENT FOR MEDICARE PATIENTS - MEDICARE RELEASE

Under the Medicare Law, effective 9/1/90, it is our obligation to process Medicare claims for our patients. In order to comply with this law, it is necessary that we have you acknowledge and sign below the following statement:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Allergic Disease Associates, PC for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine

these benefits of the benefits payable for the related services."

Signature of Patient or Legally Authorized Representative):

Name: _____

Date: _____

Relationship to Patient: _____

THE FINANCIAL AGREEMENT

We must emphasize that as specialty providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you. When you become a patient in our practice, we will ask you to sign a copy of our financial policy. Please prepare for your first visit by signing our financial policy in advance. The Asthma Center team thanks you for choosing to receive your care at The Asthma Center. It is our pleasure to care for you.

ACKNOWLEDGEMENT OF RECEIPT

ALLERGIC DISEASE ASSOCIATES, PC, T/A THE ASTHMA CENTER

FINANCIAL POLICY AND AGREEMENT:

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY FROM ALLERGIC DISEASE ASSOCIATES, PC, T/A THE ASTHMA CENTER. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION, OUR PRACTICE COLLECTION FEE, ANY LEGAL COSTS OR COURT COSTS, IN ADDITION TO THE ORIGINAL AMOUNT DUE, AS THE LAW ALLOWS.

IN ADDITION, I UNDERSTAND AND AGREE TO RECEIVING INFORMATION FROM THE PRACTICE VIA EMAIL. BY THIS AUTHORIZATION I ACKNOWLEDGE THAT THERE MAY BE INHERENT RISKS ASSOCIATED WITH ELECTRONIC COMMUNICATIONS, INCLUDING POTENTIAL DELAYS, DATA LOSS, UNAUTHORIZED ACCESS, AND SECURITY BREACHES. FURTHERMORE, I ACKNOWLEDGE AND AGREE THAT IT IS MY RESPONSIBILITY TO SECURE MY ELECTRONIC COMMUNICATION SYSTEMS TO ENSURE THE SECURITY OF SENSITIVE INFORMATION SENT TO ME. I HEREBY WAIVE ANY CLAIMS AGAINST ALLERGIC DISEASE ASSOCIATES, PC T/A THE ASTHMA CENTER (THE “PRACTICE”) FOR DAMAGES ARISING FROM THOSE RISKS ASSOCIATED WITH ELECTRONIC COMMUNICATION SYSTEMS AND AGREE TO USE THE SERVICE AT MY OWN RISK.

I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO ME AS THE PATIENT/GUARANTOR.

Name of Patient _Please Print: _____Date: _____

Signature of Patient (or Legally Authorized Representative*): _____

Date: _____

***RELATIONSHIP TO PATIENT:** _____

PLEASE PROVIDE GUARDIANSHIP OR CUSTODY OR LEGAL APPOINTMENT DOCUMENTATION