

FINANCIAL POLICY

Grand Rapids Allergy is committed to providing the best patient-focused medical care in the accurate diagnosis and optimal management of allergic diseases and asthma. In order to provide the highest quality care and establish ongoing relationships with our patients we would like to explain our financial policies. Knowing the complexity of insurance as well as some of our longer-term medical requirements such as immunotherapy, our Patient Accounts Department (616- 949-4840 ext. 40) will be happy to assist you.

- **APPOINTMENT CANCELLATION:** Because we commit 3 hours to you, we must be able to confirm your appointment one week prior to the scheduled date. If you must cancel, we need 72 hours notice in order to schedule another patient. There will be a \$100 charge for failure to appear for your visit unless cancellation is received at least 72 hours prior to the appointment date.

- **PAYMENT** OF COPAYS AND DEDUCTIBLES FOR SERVICES is due at registration unless prior arrangements have been made. To assist you, we accept cash, check, VISA and Master Card. A \$25 administrative fee will be added to all accounts if checks are returned by the bank for insufficient funds.

- **INSURANCE VERIFICATION:** We will attempt to verify your insurance eligibility and benefits prior to your appointment and assist you in calculating your potential liability on the day of your visit; however, information we receive is not always correct and does not guarantee payment. Please contact your insurance carrier to determine your allergy benefits, as there is a wide range. As an example, some plans have a 50% copay on allergy services and others have an extract maximum of \$500 per policy year. Please use the hand-out provided that contains the necessary CPT codes as well as questions to ask your carrier so you may be well informed prior to your visit.

- **PARTICIPATING INSURANCE PLANS:** We participate with AETNA PPO plans, BCBS Traditional, BCBS PPO, MESSA, Blue Care Network, Blue Choice, Direct Care, Grand Valley Health Plan, Physician's Care, Cigna, United Health Care, Priority Health Fully-Funded Plans, Priority Health Self-Funded Plans, and PPOM. We will bill your plan, provided we have all of the necessary information. If you fail to supply the correct information, you will be liable for payment in full. Please note, **we do not participate with BCBS PPO PLUS.** **For non-participating plans,** we will bill the carrier for your non-assigned claims as a courtesy.

- **BCBS MASTER MEDICAL** patients are expected to pay the entire bill at the time of service since BCBS will reimburse you.

- **MEDICARE:** We do not participate with any Medicare plan, although we will submit your claim to the original Medicare and the following Medicare Advantage Plans: Medicare plus Blue, Priority Health Medicare, Humana Gold Medicare, and Secure Horizons Medicare.

- **SELF-PAY ACCOUNTS:** if you have no insurance, payment in full is expected at registration unless previous arrangements have been made with our Patient Accounts Department. We are happy to work with you.

- **REFERRALS & AUTHORIZATIONS:** Some insurance plans require prior authorization from your primary care physician before your visit in order for you to receive maximum reimbursement for services rendered. To assist you in obtaining this authorization we must have current insurance information and the correct PCP - if we are unable to obtain authorization you will be responsible for full payment.

- **PRECERTIFICATIONS:** Please check your insurance card, and if precertification is required, it is your responsibility to obtain it. If you require our assistance, we require five-day notice prior to your appointment.

- **CHILD CUSTODY CASES:** The parent/guardian with primary custody is responsible for payment of copays & deductibles at registration. If divorce decree states medical expenses are shared, the custodial parent/guardian will still be billed for the full amount and is responsible for obtaining their own reimbursement of the shared expense from the non-custodial parent.

- **MONTHLY STATEMENTS:** Statements are sent to all patients with a remaining balance. Payment is expected within 30 days unless prior arrangements have been made with our Patient Accounts Department.

- **REFUNDS:** Overpayments will be promptly refunded or may be carried as a credit, if you prefer.

- **IMMUNOTHERAPY PROGRAM:** Patients will be notified of account balances, deductibles, copays, and/or exceeded maximum benefits upon receipt of an extract order/reorder. Payment is expected before the extract order/reorder is processed unless prior arrangements have been made. Injection copays are expected upon arriving for your injection. It is your responsibility to verify your address with each order, even if the order is placed by your PCP or other facility, and notify us promptly of any address changes, winter or vacation addresses, etc.

- **AUTOMATIC DEBIT:** We offer this service through your VISA or Master Card for any balances remaining prior to generation of monthly statements. An automatic debit form is enclosed with your new patient packet or contact our Patient Accounts Department for a copy.
- **INSURANCE CHANGES:** Please update Patient Accounts immediately when insurance coverage changes. You will be responsible for full payment if your claim is over the filing time limit for your plan.
- **CHANGE OF ADDRESS:** Please notify us promptly of any address change. If your extract is to be mailed, please notify us immediately of all address changes, whether you have moved, have a winter address, or are on vacation. If the physician's office or other facility will be ordering your extract, please advise them of any changes so that it will not be sent inappropriately. We cannot be responsible for allergy extract sent to an incorrect address, to your home while you are away, etc. All replacement vials of serum must be prepaid by the patient.

I authorize payment of medical benefits by the insured directly to Grand Rapids Allergy, PLC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am responsible for payment of all services or materials provided and for any yearly deductibles or copayment amounts. I understand that I am responsible for full payment if I have failed to provide current information and/or failed to obtain required authorizations from my primary care physician and/or precertifications required by my insurance company. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize Grand Rapids Allergy, PLC, to release any information required to process my claim. This request shall remain in effect until revoked by me in writing.

Patient/Guardian Signature: _____

Relationship to Patient: _____

Date ____/____/____

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