Financial Policy

LABEL

COMMERCIAL INSURANCE, MEDICARE AND MEDICAID: Please remember, your health insurance is a contract between you and your insurance company. It is your responsibility to know your benefits and to contact your insurance company to determine if our physicians participate with your insurance and to obtain the appropriate referral authorization or precertification before your visit. As a courtesy, we will **attempt** to verify your eligibility and benefits prior to your testing appointment(s) and one of our Patient Account Representatives will try to contact you by phone to inform you of your potential liability and to secure payment. However, information we receive is not always correct and does not guarantee insurance reimbursement. Following your appointment, you will meet with a Patient Account Representative to go over the actual charges incurred and to finalize your payment.

It is essential that you inform our office of any changes to your insurance plan so that all charges are filed appropriately and timely. Failing to do so may mean that your claims will be over the filing limit and will be denied by your insurance company, thereby becoming your responsibility.

PATIENT BALANCE: Grand Rapids Allergy (GRA) does not extend credit. All copays, and past due balances are due at check-in prior to seeing the provider for a visit and/or prior to receiving any future services including allergy extract and injections. For your convenience, Grand Rapids Allergy has established the **Auto Debit Payment Program (ADPP**) so that all outstanding balances are paid in a timely manner. This ADPP program enables Grand Rapids Allergy to obtain prior authorization from you to retain your credit card and/or bank account information in a secure file for payment of all balances owed after your insurance company pays. **NON-SUFFICIENT FUNDS**: A $25.00 administrative fee in addition to the bank fee will be added to all accounts if checks are returned by the bank for insufficient funds and bank closures.

BAD DEBT & BANKRUPTCY: If your account falls into arrears and you do not make a good faith effort to pay, your account may be referred to the ARS Collection Agency for recoupment. Grand Rapids Allergy may also dismiss you and your family members from our practice.

NO SHOW & LATE CANCEL POLICY: We ask that you notify us at least 72 hours prior to your new patient or testing appointment and 24 hours prior to your revisit appointment if you are unable to keep your scheduled appointment time. This courtesy enables our physicians and nurse practitioners to meet the needs of other patients. Failing to comply with this policy may result in a $100 charge being added to your account.

FEES: Postage and handling fees are added to all mailed extract orders. There is a **pre-payment charge for completion of various forms** requested by patients such as; school forms, FMLA forms, copies of patient records, etc. Please call the office to inquire the charge amount before submitting your request.

CHILD CUSTODY POLICY: The parent/guardian with primary custody agrees to be responsible for payment of copays & past due balances at check-in prior to seeing the provider. If 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. Parental disputes should be handled through the Friend of the Court.

IMMUNOTHERAPY PROGRAM: All patients beginning an immunotherapy program must meet with a Patient Account Representative to understand their financial responsibility. At that time, your ADPP arrangement will be established. If you prefer not to establish the ADPP an appropriate credit must be placed on the patient's account to cover the approximate cost of the extract and injections. **Since this is a 3-5 year program, extract re-orders are made automatically unless we receive notice of discontinuation in writing.** Failure to come on time for your allergy injections may require that dilutions, to adjust the strength of your extract, be made so that you may continue with the program. There is a charge for these dilutions. All past due balances must be paid prior to any new extract charges being added to your account.

For those patients receiving their allergy injections at an outside office, **GRA is not responsible for allergy extract sent to an incorrect address, to your home while you are away, etc**. When we receive a reorder from the outside office giving your injections, we will make and send the order as usual unless specific instructions are provided with that reorder**. It is your responsibility to inform the outside office if you will not be home when the extract will be mailed (typically 2-3 weeks from the date GRA receives the reorder)**. Address changes must also be communicated to GRA in writing and written on the reorder so that the extract will be mailed to the correct address. Failure to do so will result in your having to pre-pay the full amount for the replacement vial(s) as we will not be able to bill them to insurance. **Postage and handling fees** are added to all mailed extract orders.

INSURANCE BILLING AUTHORIZATION: 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 deductibles, copayments, coinsurance and non-covered 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 precertification's 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.

Print Patient/Guardian Name: _____ Relationship to Patient: _____

Patient/Guardian Signature: _____ Date: _____