ALLERGY ASTHMA IMMUNOLOGY OF ROCHESTER PC
& INFUSION CENTER
Excellence in Allergy and Asthma Care for Children and Adults

WWW.AAIR.INFO

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Financial Policy

Thank you for choosing AAIR as your allergy, asthma, immunology and infusion therapy provider. We are committed to providing you with quality health care. We have developed this financial policy to inform you of patient and insurance responsibility for services rendered. Please read it carefully, ask any questions you may have, and sign the back. A copy will be provided to you upon request.

1. **INSURANCE**. We accept most insurance plans. If you are not insured by a plan that we do business with or do not have insurance, you will be listed as Self-Pay and an estimate will be provided prior to services being rendered. Payment in full is expected at each visit. If we cannot verify your insurance coverage, payment in full is expected at each visit until coverage can be verified. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. We do not participate with New York State Medicaid. We do not take Worker's Compensation or No-Fault cases.

   We participate with most major insurance companies, such as Aetna, BlueShield PPO plans, Child Health Plus, Cigna, Excellus plans, Family Health Plus, Fidelis Care, Healthy NY, Lifetime Benefit Solutions, Medicare, Molina Healthcare, MVP Health Care, TriCare, The Empire Plan, United Healthcare and WellCare. Some plans may require a referral to receive services at AAIR. *It is the responsibility of the patient to make sure we are in your plan's network of providers, to obtain a referral if required by your plan, and to verify your out-of-pocket responsibility.*

2. **CO-PAYMENTS and DEDUCTIBLES**. All co-payments and deductibles must be paid at the time of service. All efforts are made to know your out-of-pocket cost while you are here for your visit. This arrangement is part of your contract with your insurance company. If the exact charges are not known, we'll collect a deposit. Deposits are as follows: New Patients $250, Procedures $150, Follow-up/Acute $60. We accept cash, personal checks, MasterCard, VISA and Discover. There is a $20 service charge for returned checks. After two returned checks, we will no longer accept personal checks.

3. **CREDIT CARD ON FILE**. For your convenience, we can securely store your credit, debit or HSA card in an encrypted format for future use.

4. **PROOF OF INSURANCE**. All patients must complete our patient history form before seeing their provider. We must obtain a copy of your current insurance card(s). If you fail to provide us with your correct insurance information in a timely manner, you may be responsible for the balance of the claim.

5. **CLAIMS SUBMISION**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your

responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **COVERAGE CHANGES**. If your insurances changes, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **NONPAYMENT**. If the charges are known and you fail to pay at the time of service, a $15 fee will be assessed to your account. If after 30 days from the date of your first billing statement, you have not either made a payment or arranged for a payment plan, your account will be referred to a third-party recovery agency (collections). You will be responsible for all reasonable collections charges. Please be aware that if balances remain unpaid, you will be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, our provider will only be able to treat you on an emergency basis.

8. **MISSED APPOINTMENTS.** Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for your appointment. Our policy is to charge for missed appointments canceled with less than 24 hours' notice or if you fail to show. These charges will be your responsibility and billed directly to you. Unpaid fees will be sent to collections. Repeated missed appointments could result in discharge from the practice. The following fees will be assessed for patients that fail to show or cancel with less than 24 hours' notice:

- New Patient $75
- Procedure $75
- Follow-up, Bio. Inj. or Acute $50
- Allergy Shot $25
- Infusion $75

If you have questions or would like an estimate for services, please call the Billing Office at (585) 442-0150 option 4.

Please complete:

Primary Insurance Company_____

Subscriber Name_____ ID #_____ DOB_____

Claims Mailing Address_____

Insurance Phone #_____

Secondary Insurance Company_____

Subscriber Name_____ ID #_____ DOB_____

Claims Mailing Address_____

Insurance Phone #_____

I have read, understand and accept the terms of the AAIR Financial Policy.

_____ _____

Print patient's name If patient is a minor, print parent/guardian's name

_____ _____

Signature of patient/parent/guardian Date