IDAHO ALLERGY & ASTHMA
WENDELL E. PETTY, M.D.
DAVID A. PETTY, D.O.
PHIL MARLOWE, P.A.

3422 SOUTH 15th EAST
IDAHO FALLS, ID 83404
(208) 529-9292

## FINANCIAL POLICY

Thank you for choosing us as your Allergy/Asthma provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read, agree to, and sign prior to any treatment.

Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

If you have insurance, we will bill them for you, but deductibles and patient co-payments are due at the time of services. Being a preferred provider for your insurance does not guarantee the services we provide will be covered. It is your responsibility to know and comply with the terms of your insurance contract. In the event your health plan determines a service to be "not covered," or if payment is denied due to your failure to comply with the terms of your insurance (i.e., no referral, pre-existing condition, etc.), you will be responsible for the complete charge. **Call your health plan if you have any questions regarding your coverage.** If your insurance has not paid within 30 days, please contact them and check on the status of your claim. If we have not heard from your insurance within 60 days of billing, you will be responsible for payment of the balance on your account.

**Attention Medicaid Covered Patients:** If we do not have a current referral from your Primary Care Physician at the time of service, you will be responsible for all charges associated with the appointment.

If you have no insurance (self-pay), payment is due at the time of service unless payment arrangements have been made prior to your visit.

If you are being seen due to a work related injury, you will need to provide us with a case number as well as insurance name and address for billing purposes prior to being seen.

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply to this office:

1. Pay the doctor at the time treatment or service is received or
2. Pay the doctor according to arrangements made prior to receiving any service or treatment

You agree to pay costs and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit. If it becomes necessary to collect an account by legal action, the responsible party will need to pay **ALL** fees incurred.

If payment by check is returned to us for Non-Sufficient Funds, you will be charged a $25.00 fee in addition to the total of the check.

You agree to give 24 hour notice for the cancellation of an appointment, except in an emergency situation. **You agree to pay a $50.00 fee for missed appointments.**

In case of a divorce, the doctor is not a party to the divorce settlement. If your ex-spouse is obligated to pay, it is **your** responsibility to see that the account is paid, not IAAC.

Thank you for trusting us with your care. Please feel free to contact our office with any questions you may have regarding payment options or financial responsibilities.

**I have read, understand, and agree to the provisions of this Financial Policy which includes your agreement for payment at time of treatment unless other arrangements are made prior to service or treatment. I hereby authorize the use and discloser of my individually identifiable PHI as stated in the Notice of Use and Disclosures except as excluded by addendum.**

| Patient Name | Authorized Signature | Date |
|---|---|---|

If not signed by the patient, please indicate relationship:

____ Parent, guardian, or caregiver of a minor patient
____ Beneficiary or personal representative of a deceased patient
____ Guardian or conservator of an incompetent patient
____ Other: _____

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***NOTE: If your insurance requires a referral from your primary physician, it is your responsibility to obtain the referral and have it sent to our office.***

## NOTICE OF USE AND DISCLOSURES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**
***PLEASE REVIEW IT CAREFULLY.***

I hereby authorize Idaho Allergy and Asthma Clinic (IAAC) to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described.

Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Your PHI may be used as necessary to support the day-to-day activities and management of IAAC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Your PHI may be disclosed to law enforcement agencies or to public health agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting as required by law.

Your PHI will be used by our staff to send you appointment reminders.

Your PHI may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Your PHI may be overheard by others who are not employees within our office due to the open atmosphere.

IAAC will not use your PHI for fundraising or marketing purposes.

### OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION

Disclosure of your PHI or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization. Without your authorization, we are expressly prohibited to use or disclose your PHI for marketing purposes when financial remuneration is involved. We may not sell your PHI without your authorization. We may not use or disclose most psychotherapy notes contained in your PHI. We will not use or disclose any of your PHI that contains genetic information that will be used for underwriting purposes.

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying IAAC in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by IAAC in reliance on this authorization before IAAC receives my request for revocation or modification. I must sign and date my written request and send it to:

Idaho Allergy and Asthma Clinic
3422 South 15th East
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Attn: Medical Records Department