Payment Policy

Thank You for choosing our practice. We are committed to providing you with quality and affordable healthcare. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions that you may have and sign in the space provided. Our patient information forms must be completed before being seen. If not completed prior to your scheduled visit the appointment may be rescheduled. A copy will be provided to you upon request.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. If your insurance company does not pay your claim within 60 days; the balance will automatically be billed to you. If you are insured by a plan that we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

Proof of Insurance: We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If we do not receive the correct identification and insurance information at the time of service, you may be responsible for the balance of a claim.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can adjust your coverage to help you receive your maximum benefits.

Co- payments, Deductible & Balance Due: All co-payments- Deductibles, Co-insurance & balance due must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud.

Claims Submission: 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 your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Once your insurance company has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing what your total patient responsibility is. If you disagree with the patient amount owed, it is your responsibility to contact your insurance carrier immediately.

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Referrals: If your insurance plan requires a referral authorization you are responsible to ensure that the referral has been approved prior to being seen. If you are seen without an authorized referral, you will be billed and responsible for all non-covered services.

Network Status: We attempt to verify your network coverage status. This arrangement is part of your contract with your insurance company. Please contact your insurance company to verify network coverage concerns prior to your appointment.

Non-covered services: Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. Since all insurance plans are different, please contact your insurance company or HR department for detailed information about what is covered or not covered including allergy testing, immunizations, etc. You will be billed and responsible for all non-covered services.

Balance Due: An **outstanding balance fee of 1.5%** of the total bill for each month that your bill remains past due will be added to your account.

Patient Statements: If you have unpaid balance, you will receive a statement every 30 days, which can be sent to your patient portal account or mailed. For mailed statements a **billing fee of $5.00 for each statement mailed** will be added to your account balance to cover our cost. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt.

Late Policy: We understand the potential for unforeseen circumstances that can arise that may cause a late arrival or missed appointment. If this happens, please call us as soon as possible so we can change your appointment status accordingly and make it available for another patient.

If you arrive more than 15 minutes late for your appointment an attempt will be made to see you as allowed by our schedule on a next-available basis. If unable to find a mutually agreeable time, you may be asked to reschedule.

No Show Fee: Please cancel/reschedule your visits within 1 business day (24 hours' notice). Notice given **after business hours or on weekends** will be considered received on the **next business day**. At our discretion, a fee of **$125 for a new visit** or **$75 for an established visit**. Three no show appointments within a 12-month period will result in eligibility for discharge from the practice for the family.

Collection Fees: Balances that have not had a payment made within 60 days will be turned over to collections. Guarantor will be responsible to pay all costs of collections including reasonable

interest, reasonable attorney's fees, and reasonable collection agency fees. If this is to occur, you will be notified that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

Methods of Payment: We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Payments may be made conveniently through your **patient portal account** under the Account Balance/Statement tab. You can access the patient portal by following the link: https://mmdas.modulemd.com/PatientMMD/login

Credit Card on File Policy (CCOF):
At Premier Allergy of Texas, we require keeping your credit, debit or HSA card on file as a convenient method of payment for the portion of services that your insurance doesn't cover and which you're liable for. At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored securely off-site. No credit card numbers will be stored at our practice.

Once we receive your Explanation of Benefits (EOB), **balances of $50 or less will be charged immediately to CCOF**. Otherwise, you will receive notification for the balance due through your Module MD patient portal account. Your credit card will be charged for the outstanding balance that is your responsibility 5-days after issuance of notification. If you wish to give a different payment other than the card on file, call our office to make alternative arrangements.

It is your responsibility to ensure that the card you have on file is not expired or cancelled and has an appropriate amount of available credit. Please call our office immediately if you need to update your CCOF. If your payment is declined, a **$35 declined payment fee will be applied,** and a notification will be made. If we receive no response within 30 days of the notification date, your account will be sent to a collection agency. We will remove the declined payment fee when you respond to the notification and arrange for payment.

- Please note that all your rights with respect to the use of your credit card will remain in effect. This policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment.

Using credit card on file, you will be able to:

- Pay balances conveniently
- Receive timely refunds
- Make payments automatically using your credit card of choice
- Avoid statement and outstanding balance fees

- Avoid writing checks and postage fees by paying through the mail
- Receive notifications and receipts electronically

Your credit card on file can be used for the following reasons:

- Outstanding balance
- Fees as described in PATX Payment Policy
- Insurance discrepancies

Credit Card on File non-participation:
At the time of booking new and established appointments a charge of $65 and $40 respectively will be collected to hold your appointment and will be applied to your balance at the time of your visit or refunded.

Statement Preference:
☐Portal
☐Mailed *($5.00 fee will apply)*

Credit Card of File Preference:
☐Participate
☐Not participating *(appointment hold charges will apply)*

Patient's Name: _____

Responsible Party: _____

The ***Responsible Party*** is the person who is **FINANCIALLY** responsible for the patient's account(s) and who will receive all account statements to their address. By signing, I understand that I am the responsible party and will adhere to the requirements outlined in the policies provided to me for the following patients as well as future patients registered in my name at Premier Allergy of Texas.

Signature: _____

Date: _____

Office Use: Received By: _____ Date: _____

****** IMPORTANT: VERIFY PATIENT COMMUNICATION EMAIL ON FILE FOR PORTAL COMMUNICATION ******

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Credit Card Authorization Form

I authorize Premier Allergy of Texas to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Discover ☐ Mastercard ☐ Visa

*****Do not provide full credit card number on this form*****

Last 4 Digits of Credit Card Number: XXXX-XXXX-XXXX-_____

CVV: _____

Expiration Date: _____ / _____ / _____

Cardholder Name: _____

Signature: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

I (we), the undersigned, authorize and request Premier Allergy of Texas to charge the above credit card for balances due that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Premier Allergy of Texas.

This authorization will remain in effect until I (we) cancel it. To cancel, I (we) must give a 45-day notification in writing to Premier Allergy of Texas, and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____