



## PAYMENT POLICY

Thank you for choosing our practice. We are committed to providing quality, affordable healthcare. The following information addresses frequently asked questions regarding patient and insurance responsibilities for services rendered. Please review this document carefully, ask us any questions you may have, and sign in the space provided. Billing communications and payment notifications are considered healthcare operations under HIPAA and are handled in accordance with our Notice of Privacy Practices. All patient information forms must be completed prior to being seen. A copy will be provided 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 agreed-upon arrangement.

**Insurance:** We participate with most insurance plans and will bill your insurance company as a courtesy to you. While we may estimate coverage, **your insurance company makes the final determination of eligibility and payment.** If your insurance company does not pay your claim within **60 days**, the remaining balance will automatically be billed to you. If you are insured by a participating plan but do not have an up-to-date insurance card, **payment in full is required at the time of service** until coverage can be verified.

**Proof of Insurance:** We require a copy of your **driver's license and current, valid insurance card** at each visit. Failure to provide correct identification and insurance information at the time of service may result in you being responsible for the full balance of the claim.

**Coverage Changes:** Please notify us of any insurance changes **before your next visit** so we can update your information and help you maximize your benefits.

**Co-payments, Deductibles, and Balances Due:** **All co-payments, deductibles, co-insurance, and outstanding balances must be paid at the time of service.** This requirement is part of your contract with your insurance company, and we are contractually obligated to collect these amounts in full.

**Claims Submission:** We will submit claims on your behalf and assist as reasonably possible in facilitating payment. Your insurance company may require information directly from you; it is your responsibility to comply. Please note that **you are ultimately responsible for your account balance**, regardless of insurance payment. Your insurance policy is a contract between you and your insurer.



## PAYMENT POLICY

After processing, your insurance company will issue an **Explanation of Benefits (EOB)** to both you and our office outlining your financial responsibility. **If you disagree with the amount owed, you must contact your insurance carrier promptly.**

**Referrals:** If your insurance plan requires a referral or authorization, it is your responsibility to ensure approval **before your appointment**. Services rendered without an authorized referral will be billed to you and are your responsibility.

**Network Status:** We make every effort to verify network participation; however, **verification remains your responsibility**. Please contact your insurance company prior to your appointment with any network-related questions.

**Non-Covered Services:** Some services may not be covered or may be deemed not medically necessary by your insurance plan. Coverage varies by policy. You are encouraged to contact your insurance provider or HR department for clarification. **You are responsible for payment of all non-covered services**, including but not limited to allergy testing and immunizations.

**Late Arrival Policy:** We understand unforeseen circumstances may occur. If you anticipate being late, please contact us as soon as possible.

Patients arriving **more than 15 minutes late** may be seen on a next-available basis if scheduling allows. Otherwise, rescheduling may be required.

**No-Show Policy:** Please cancel or reschedule appointments **at least 24 hours (one business day) in advance**. Notices provided after business hours or on weekends are considered received the next business day.

At our discretion, the following fees may apply:

- **\$75** for a new patient visit
- **\$50** for an established patient visit

**Three no-show appointments within a 12-month period may result in discharge from the practice for the entire family.** Any discharge from the practice will follow applicable professional standards and include written notice and emergency care provisions.

**Collections:** Patients experiencing financial hardship may contact our billing department to discuss payment options. Accounts with no payment activity for **60 days** may be referred to a collection agency. The guarantor will be responsible for all related costs, including reasonable interest, attorney fees, and collection agency fees. Interest, if applied, will not exceed amounts



## PAYMENT POLICY

permitted by applicable law. If your account is referred to collections, you will be notified and allowed **30 days** to secure alternative medical care. During this period, services will be limited to **emergency care only**.

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

Payments may also be made conveniently through your **patient portal** under the *Account Balance/Statement* tab: 🖱️ <https://mmdas.modulemd.com/PatientMMD/login>

### **Credit Card on File Policy (CCOF)**

Premier Allergy of Texas requires a credit card, debit card, or HSA card on file for payment of any portion not covered by insurance. Your credit card information is **not stored** in our office systems. All payment information is securely encrypted and processed through a certified third-party payment processor that complies with industry standards and HIPAA privacy regulations.

After we receive your insurance Explanation of Benefits (EOB), we will notify you of any balance owed. Following this notification, and consistent with your authorization, the balance may be charged to your card on file.

It is your responsibility to ensure that the card on file is valid and has sufficient funds. Declined payments will incur a **\$35 declined payment fee**. If no response is received within **30 days**, the account may be forwarded to collections.

This policy does not limit your rights to dispute charges or question insurance determinations.

You authorize Premier Allergy of Texas to initiate charges consistent with this policy.

### **Using a Credit Card on File Allows You To:**

- Pay balances easily and securely
- Receive refunds promptly
- Automate payments
- Avoid paper statements and mailing delays
- Receive electronic notifications and receipts

### **Your card may be used for:**

3 of 5

Ver: 20260420



**PAYMENT  
POLICY**

- Outstanding balances
- Fees outlined in this Payment Policy
- Insurance discrepancies

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 \*\*\***



**PAYMENT  
POLICY**

**Credit Card Authorization Form**

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

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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_