Advanced Allergy & Asthma Care

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ADVANCED ALLERGY & ASTHMA CARE, PLLC

Dr. Rima Sanka, D.O. Dr. Latha M. Chamarthy,M.D. Melissa Swertfeger, APRN

STATEMENT OF FINANCIAL RESPONSIBILITY

As a courtesy to you, our office will submit claim(s) to your Health Insurance Carrier(s) for the services provided to you or your covered family members. You will be responsible for any and all Co-Payments, Deductibles and for charges not covered by your health insurance carrier(s). All payments are due during the time of service based on available information.

If no payment is received from your insurance carrier(s) within 90 (ninety) days from the date of service, the bill becomes your responsibility. Our office will bill you for the amount owed. In the event your insurance carrier(s) denies payment to the claim(s) or pays only partial payment, the bill becomes your responsibility. In the event your insurance carrier(s) sends payment to you directly, you agree to pay that amount immediately to our office. ***Should the account be referred to collection procedure, the undersigned shall be responsible for collection costs and attorney fees***.

OUR OFFICE POLICY CONCERNING APPOINTMENTS

The doctors limit the number of appointments they make on a daily basis, so that they can spend adequate time with each patient to provide the highest quality of medical care. Short notice cancellations, no shows, and rescheduled appointments significantly impact the schedule. We always call to confirm your appointment, which should be sufficient time to know if you can keep your scheduled appointment or not. It costs a lot of money to run a medical practice. Broken appointments, cancellations with short notice, and no shows not only significantly hurt our revenue but also prevent us from providing our services to the patients in real need during those times. There have been several no shows and canceled appointments in the past, which forced us to bring the following policy into effect: ***If you are late without notification, we will have to reschedule your appointment at the next available time. If you no show, cancel or try to reschedule your appointment on the day of the appointment, there is a $50.00 charge prior to scheduling the next appointment. A total of 3 no shows will result in termination from the practice.***

I hereby read and agree with the STATEMENT OF FINANCIAL RESPONSIBILITY AND OUR OFFICE POLICY CONCERNING APPOINTMENTS, as described above:

Patient's Name: _____ Today's Date:_____
(Please Print)

_____ _____
Patient/Parent/Legal Guardian's Name (Please Print) Patient/Parent/Legal Guardian's Signature

Authorized Facility Signature: _____Today's Date:_____

HIPAA PATIENT QUESTIONNAIRE

1. Please list the family members, or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name: _____ Ph Number:_____
Name: _____ Ph Number:_____

Print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home. **(Confidential Communications)** Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"confidential." YES _____ OR NO_____**
I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

Signature:_____ Date:_____