ALLERGY & ASTHMA ASSOCIATES

Patient's Name	M ____ F ____	Date of Birth
Address (street) (city)	(state)	(zip code)
Home Telephone	Work Telephone	Cell Phone
Email Address	Social Security Number	
Marital Status		
Employer of Patient	Occupation	
Referred By	Primary Care Physician	

How did you first hear about us?	____ Friend	____ Physician	____ Website	____ Yellow Pages	____ Other	Explain: ________

Person Responsible for Account

Name	Relationship	
Address (street) (city)	(state)	(zip code)
Home Telephone	Work Telephone	Cell Phone
Email Address	Social Security Number	
Employer	Occupation	

Office Policy Regarding Payment

Co-payments and deductibles are due at the time services are rendered. We will happily submitt all insurance claims as a courtesy to our patients.

For those insurance plans requiring referrals, it is YOUR RESPONSIBILITY TO OBTAIN THE REFERRAL or payment will be expected when services are rendered.

Primary Insurance	Subscriber
Policy/Membership Number	Group Number
Claim Address	Telephone Number
Secondary Insurance	Subscriber
Policy/Membership Number	Group Number
Claim Address	Telephone Number

I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to the undersigned physician for services rendered. A photocopy of the agreement shall be valid as the original.

Signature ______________________________ Date __________

I recognize that I am responsible for charges incurred for services rendered and agree to pay those charges. (deductibles, co-payments and non-covered services)

Signature ______________________________ Date __________

Allergy and Asthma Associates, P.A.
Patient Financial Agreement

Patient Name: ________________________________ **DOB:** __________ **Date:** ___________

Dear Patient,
Thank you for choosing Allergy and Asthma Associates, P.A. for your healthcare needs. We value our relationship with you and would like to tell you about the financial aspects of our services. Some of the information outlined within this policy includes our obligations to comply with insurance, Federal, Privacy and Fair Collections Acts. Your financial responsibilities related to your healthcare are included as well.

Red Flags Rule
The Federal Trade Commission developed a set of rules to protect consumers against identity theft. In order to protect your identity we may require a photo ID & Insurance Cards at each visit.

HIPAA
In compliance with HIPAA regulations, we are unable to discuss details of services rendered or to produce an itemized bill for any parties that are not the patient, unless authorized in writing by the patient.

Copayments, Deductibles & Co-Insurance Fees
Fees are based on the complexity of your visit or procedure. When you sign up for your insurance they will notify you of your out of pocket expenses such as a copayment, deductible or co-insurance. These terms are between you and your insurance and our office is not authorized to make any changes of any kind to these terms. Out-of-pocket expenses will be collected by our staff during your visit and are not contingent upon your receipt of a statement. We accept Visa, Master Card, Discover, and American Express, cash, personal checks and money orders. We accept secured payments over the phone at (410) 647-2600 or online through our patient portal (https://10921.portal.athenahealth.com/).

Form Completion & Medical Record Copying Fees
We do charge for the completion of school and/or camp medication forms. Attorney requests are subject to Maryland State Medical Records copying fees as outlined in our Records Fees Policy. Our office will notify you when documents are ready for pick up.

Late Arrival to Appointment
If you arrive to your appointment 15 minutes late, or later, we may need to reschedule your appointment.

Missed or Cancelled Appointments
As a courtesy to other patients who need to be seen, if you need to cancel your appointment please notify us at least 24 hours in advance. If we are not contacted 24 hours in advance to cancel an appointment, then a fee of $25.00 will be applied to No Show appointments for existing patients and $75.00 for new patients.

Returned Check Charge
Checks and credit card payments returned for non-Sufficient Funds (NSF) are subject to a $35.00 Fee (in addition to fees from your bank). Cash payments will be expected after more than one NSF fee.

Self- Pay Patients
Our practice will give you an estimate of what will be due. Sometimes it is medically necessary to add services after a care plan has been established. When this occurs, we will notify you of these costs. Payment for all

services is due at your visit. In the event you have insurance but do not provide us with the proper referral or authorization from a PCP or insurance, the patient will be responsible for payment.

Payment Plans

In some instances, our office will work with you to develop a plan to assist you in paying outstanding balances with our practice. Our billing department can be reached at (410) 647-2600 or through our patient portal.

Coordination of Benefits

Sometimes you may have more than one insurance company paying for your medical expenses. In order to have the correct insurance pay on your behalf, you must notify us of the correct sequence of primary, secondary and/or tertiary. Failure to do so could result in all insurances denying your medical claims. If you do not provide us with accurate insurance and coordination of benefits information in a timely fashion you may become responsible for the full charges due.

Non-Payment of Outstanding Accounts

We make many efforts to assist our patients with managing their medical bills. Please contact us if you are having difficulty with payments. Accounts that are not paid in a reasonable amount of time will be sent to an external collection agency. Should the account be referred to a collection agency or an attorney for past due amounts, the guarantor may incur attorney's fees, court costs and all applicable collections expenses.

Referrals

Some insurance carriers require that you obtain a written referral from your primary care physician for our specialty services. Patients are responsible for obtaining referrals from their Primary Care Physician (PCP) and bringing them to the visit with us. If you have forgotten your referral, we require completion of our "No Referral Waiver" agreement in order to be treated. We will only perform services and file claims to your insurance for authorized services approved by your insurance carrier's guidelines. Payment for services that have not been approved by a PCP are considered self-pay and payable at the time of service.

Assignment of Insurance Benefits and Third Party Claims

By signing this document you authorize benefits from your insurance company to be made on your behalf to Allergy and Asthma Associates, P.A. for services furnished to you by our providers. You also authorize release of your medical information necessary to process your insurance claims. If you do not agree with this then our office will be unable to submit insurance claims on your behalf and payment in full will be expected from the patient prior to services being provided.

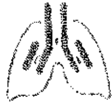
Financial Attestation

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the financial balance of any services provided to me. I also understand that it is my responsibility to know what the terms of my insurance are and to be in compliance with those terms. Payment is due at the time services are rendered which includes co-payments, deductibles, and co-insurance with my carrier.

I have read both pages of this document and agree to the terms outlined. I will notify the office of any changes in my personal address, contact, and/or billing information.

Name of Patient: ____

Signature of Patient: ____ Date: ________



Allergy and Asthma Associates, P.A.
James Banks, M.D. & Timothy Andrews, M.D.

Permission to Leave Messages

I, ______________________________, (patient/parent) hereby grant permission to Allergy and Asthma Associates, P.A. to:

- ☐ Leave detailed messages on my voicemail that may contain my personal health information.
- ☐ Leave detailed messages with another member of my household/family that may contain my personal health information.

I understand that I will need to provide a written request to Allergy and Asthma Associates, P.A. if I choose to relinquish this permission.

Form completed for:

[ ] Patient______________________________

______________________________ ____________________
Signature Date

277 Peninsula Farm Road, Arnold, MD 21012
(o) 410-647-2600 (w) www.annapollendocs.com (f) 410-647-4953