**Financial Responsibility Policy**

1. I understand that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am responsible for confirming my medical benefits (or those of my dependents) with my insurance group and that I am expected to have this information at the time of my visit.

 **Patient Initials**\_\_\_\_\_\_\_\_

1. I understand that Stone Oak Allergy Asthma & Immunology cannot guarantee that the information received from my insurance company is accurate. I am fully responsible for all charges deemed my responsibility to my account. **Patient Initials**\_\_\_\_\_\_\_\_
2. I understand that Stone Oak Allergy Asthma & Immunology will bill my insurance company according to all Federal rules and regulations and provide my insurance company with copies of all appropriate and required information. Stone Oak Allergy Asthma & Immunology is not responsible for lost claims. **Patient Initials**\_\_\_\_\_\_\_\_
3. I understand that Stone Oak Allergy Asthma & Immunology will make any reasonable effort to assist me in resolving any disputed claims or payment for such claims; however, the contractual relationship for payment of such claims lies solely between myself and my insurance carrier and I am ultimately responsible for all services provided.

 **Patient Initials**\_\_\_\_\_\_\_\_

1. I understand that if my plan is out-of-network or services are determined “non-covered” due to plan provisions, preexisting conditions, or riders on my policy, I am fully responsible for services incurred. **Patient Initials**\_\_\_\_\_\_\_\_
2. I understand that if I elect to pay privately at my first visit due to lack of insurance, lack of coverage, failure to provide my insurance card at the time of service, or failure to verify coverage, Stone Oak Allergy Asthma & Immunology will not retroactively submit claims or change account responsibility. **Patient Initials**\_\_\_\_\_\_\_\_
3. I understand that it is my responsibility to provide accurate and updated insurance information to Stone Oak Allergy Asthma & Immunology at every visit, if applicable.

 **Patient Initials**\_\_\_\_\_\_\_\_

1. I understand it is my responsibility to be involved proactively in obtaining required referrals that may be required to obtain care, depending on my insurance policy.

 **Patient Initials**\_\_\_\_\_\_\_\_

**Assignment of Benefits**

1. I understand and agree that I am financially responsible and must pay all deductibles, co-payments, and amounts disputed by my insurance carrier for healthcare services rendered by Stone Oak Allergy Asthma & Immunology to me or my dependent(s).

 **Patient Initials**\_\_\_\_\_\_\_

1. I understand and agree that Stone Oak Allergy Asthma & Immunology may utilize any legal means to collect payment for any healthcare services rendered to me or my dependent(s). In the event that legal action is taken, in order to enforce the terms and conditions of this agreement, the prevailing party shall be entitled to recovery of all attorney and or collection fees and costs. **Patient Initials**\_\_\_\_\_\_\_

**No-show/Late Fee and Card-On-File Policy**

**For all appointments, we require a 24 hours’ notice in the event of cancellation or rescheduling.** If full notice is not provided, we will bill **a $35 no show fee** for medical appointments. Additionally, if you are more than 15 minutes late to your appointment and there is insufficient time to perform the appointment, the appointment may be cancelled or rescheduled and you will be subject to a **$35 fee**. **Patient Initials**\_\_\_\_\_\_\_\_

Our policy is to have an active credit card on file to charge immediately for services, past due balances, payment plans, and no-show fees. **Patient Initials**\_\_\_\_\_\_\_\_

Please indicate a maximum amount per month you authorize your card to be ran for, if you do not have an active payment plan established and have a patient balance due: $\_\_\_\_\_\_\_\_\_\_\_\_. *(Minimum amount of $25 is required****)* Patient Initials**\_\_\_\_\_\_\_\_

**Type of card:** Visa Mastercard Discover American Express Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Card Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Security Code:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiration Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name on Card:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, you acknowledge that you have read, understand, and agree to our financial policy, assignment of benefits, no-show/late fee policy, and card on file policy. You authorize Stone Oak Allergy Asthma & Immunology to use the information above for all payments. You also understand that HIPAA privacy laws prevent Stone Oak Allergy Asthma & Immunology staff from using the above information for any other purposes.

Patient’s full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_