**ELITE ALLERGY AND ASTHMA CLINIC**
**FINANCIAL POLICY**

PATIENT NAME _____DOB:_____

**CONSENT FOR CARE AND TREATMENT:**

I, the undersigned, do hereby agree and give my consent to Elite Allergy and Asthma Clinic to provide medical care, recommendations and treatment considered necessary and proper in diagnosing or treating the above named patient.

Patient/Responsible Party Signature: Sign:_____Date _____

**FINANCIAL POLICY/NOTIFICATION OF PATIENT RESPONSIBILITY:**

Elite Allergy and Asthma Clinic will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered.

It is the responsibility of the patient to make sure we are on your insurance and in your network.

It is the responsibility of the patient to be sure they acquire the appropriate referrals and /or prior authorizations as needed by the insurance. In the event your insurance company establishes a usually and customary fee schedule, you will be responsibility for remaining balance.

If any payment is made directly to you for services billed, you recognize an obligation to submit same payment to Elite Allergy and Asthma Clinic.

Insurance companies require us to collect your co-payments, co-insurance, and /or any unmet deductible amounts from you at the time of services.

In the event that a personal check is returned for Non-Sufficient Funds, a $50 service fee will be charged to you.

Initial: _____

**Insurance verification:**

We will/have verified your medical benefits with your insurance, based upon the information you provided. Please be aware that your insurance has a disclaimer that this is VERIFICATION OF BENEFITS only and does not guarantee payment. Benefits/payment is determined once the claim is received.

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**Cancellation Policy:**

We do charge a $25 fee if you do not show up to a scheduled appointment or cancel the same day as your appointment. Please call us 24 hours in advance if you have to cancel your scheduled appointment.

Initial: _____

We reserve the right to refuse service to anyone at our discretion in non-emergency situations. By signing below, I acknowledge that I have read the above information, and that I am ultimately financially responsible for my treatment. I understand and agree that if I fail to make any payment that I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including but not limited to cost, collection agency and/or attorney's fees.

Patient/Guardian signature: _____Date:_____