



Family Allergy & Asthma Financial Agreement

What we will do:

- As a service to you, we will contact your insurance company to obtain benefit information about the services we provide if sufficient information is provided to us prior to your appointment. *These benefit quotes are not a guarantee. You will be responsible for any amount your insurance processes as patient responsibility.*
- We will file a claim with your insurance company if proper information is provided. We participate with Medicare and the majority of major insurance companies.
- Our billing department will be glad to answer any questions regarding charges, payment plans and insurance participation. We can be reached at 1-800-999-1249 or 1-502-429-8585 ext 696.

Your responsibilities:

- Please provide complete and current insurance information several days prior to your appointment. You may provide this information by telephone or fax a copy of the front and back of your insurance card to our billing department at 1-502-753-0889.
- Contact your insurance company to determine coverage under your policy for allergy benefits and if your plan requires a referral for services by a specialist.
- If your policy requires a referral, it is your responsibility to obtain it prior to your appointment. Bring the referral to your appointment or have your primary care physician fax the referral to us at 1-502-753-0889 prior to your visit. *You may be responsible for the entire bill if a referral was not obtained prior to services being rendered.*
- Be prepared to pay all co-payments and deductibles at the time of your visit. You may pay by cash, check, Visa, MasterCard, American Express or Discover.

Insurance Release:

I hereby authorize Family Allergy & Asthma to release any information to my insurance company, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care. I also authorize and request any and all benefits to be made directly to Family Allergy & Asthma with regards to any pending claims for medical treatment or services. I authorize payment of Medicare benefits to be made directly to Family Allergy & Asthma.

I understand I am financially responsible for any and all charges not covered by insurance. I understand that it is my responsibility to obtain a referral or preauthorization prior to my visit if my insurance so requires.

x _____ Date _____
Signature of Insured