

Allergy & Asthma Consultants of Montana, PLLC
FINANCIAL POLICIES

We feel it is important for our relationship with you that you understand our financial policies. Please read this carefully, and ASK IF YOU HAVE ANY QUESTIONS.

PATIENTS WITH INSURANCE

To file any claims, we must have copy of your current insurance information. If your insurance changes, you must provide us with the new information or you will be responsible for all of the charges on your account.

We require a deposit of \$100 at your first visit. If your insurance company pays the entire balance, we will refund your deposit. If the insurance company pays a portion of the charges, we will apply your deposit to your account and bill you for the balance.

If we have not received payment from your insurance company within 60 days of your visit, we will apply your deposit and bill you for the balance.

We are "participating providers" with the following insurance companies: BLUE CROSS/BLUE SHIELD, ALLEGIANCE, NEW WEST, TRIWEST, MEDICARE and MEDICAID. You are still responsible for any co-payments and deductibles not covered by your plan at the time of service.

SELF-PAY PATIENTS

You are responsible for payment of services at the time of your visit. We offer a 10% discount for visits paid in full at the time of service. If you need to arrange payment options please speak with Rhonda in our business office.

MINOR PATIENTS (under the age of 18)

The adult accompanying a minor is responsible for payment of the minor's account. If there is a financial arrangement with another adult, we need written authorization from the person who is responsible for payment.

ADULT PATIENTS (over the age of 18) WHEN ANOTHER ADULT IS FINANCIALLY RESPONSIBLE FOR YOU

We need written authorization, including address, from the person who is responsible for payment.

PAYMENT OPTIONS:

You may select:

- Cash, Check, Visa, MasterCard, or Discover
- NO INTEREST Payment Plans from CareCredit
 - o Allow you to pay over time with NO INTEREST
 - o Low monthly payment plans available
 - o No annual fees or pre-payment penalties

****WE CHARGE A \$15 FEE FOR RETURNED CHECKS**

****IF IT BECOMES NECESSARY TO SEND YOUR ACCOUNT TO COLLECTION, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION AND LEGAL FEES INCURRED.**

I have read and understand the above policies, and I have had all my questions answered.

Patient/Guardian Signature

Print Patient Name

Date