The Virginia Center for Allergy & Asthma

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FINANCIAL STATEMENT

INSURANCE

I/The Policyholder hereby authorize The Virginia Center for Allergy and Asthma to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with my regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration.) A copy of the authorization may be used in place of the original. This authorization may be revoked by either myself or my insurance carrier at any time in writing.

The Virginia Center for Allergy and Asthma will make every effort to contact your insurance company to verify your benefits. However, verification of benefits is not a guarantee of payment. If the insurance denies payment or services that are not covered, the Policyholder will become financially responsible for these services.

Patient/Responsible Party Initials: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to The Virginia Center for Allergy and Asthma for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agreed that I am financially responsible for charges not paid by my insurance company.

Patient/Responsible Party Initials: _____

PAYMENT POLICY

I understand that payment for services is due at the time services are rendered. All returned checks are subject to a $25.00 Return Check Fee. If it becomes necessary to refer my account to an outside collection agency, I agree to pay 33.3% interest on the debt. I authorize Virginia Center for Allergy and Asthma and their business partners to call my cell phone for collection of the debt.

Patient/Responsible Party Initials: _____

MISSED APPOINTMENT POLICY

I understand that if I do not give a minimum of 24 hours notice for cancellation of an appointment, I will be charged a $50.00 No-Show Fee that is not covered by the insurance plan.

Patient/Responsible Party Initials: _____