The Virginia Center for Allergy & Asthma

Robert A. Sikora, M.D., FACAAI
Darshana Alle, M.D.

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 Return Check Fee. If it becomes necessary to refer my account to an outside collection agency, I agree to pay Collection Fees and/or Attorney Fees. I authorize Virginia Center for Allergy & 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: _____

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VCFAA Patient Payment Options

We, at the Virginia Center for Allergy and Asthma, are dedicated to providing the best care possible to our patients, in a timely and cost-efficient manner. We also understand that many insurance policies have high patient deductibles that must be met before health insurance begins paying for services. We offer three options for payment of those high deductibles to ease the burden, as best as possible, for you, the patient.

Payment Option 1

Full payment at the time of billing is always appreciated.

Payment Option 2

If paying by check, we offer a monthly payment plan over 4 months, with ¼ of the total bill paid monthly for the 4 months.

Payment Option 3

This option is available to those who provide credit card information on file to be automatically charged monthly over a 12-month period.

Please provide credit card information in the space provided so that we may process your card monthly.

Name on card _____

Card number _____

Expiration date _____ **CVV2/CID #** _____

Total Amount Due $ _____ **Payment Amount $** _____

Day/Date to charge cc _____

Patient Account # _____ **House #** _____ **Zip Code** _____