Allergy & Asthma Center, P.C.

Credit Department - 541-485-5652

The accompanying brochure describes our practice and the insert provides the costs for some of our services. You are encouraged to inquire about any service or procedure not listed, as we understand this may influence your decision to undergo such care.

The following is information regarding our credit policies. Please read it, sign it and give it to the receptionist with the registration form. If you have questions regarding any of these policies, please do not hesitate to discuss them with our bookkeeper.

1. A $50.00 - $100.00 deposit or your copayment, is required at the time of the first visit depending upon insurance coverage. Copayments are always due at the time of each visit.
2. Balances not covered by insurance are due within 30 days of the initial billing unless satisfactory arrangements have been made with our credit department.
3. Balances covered by insurance are due within 60 days of the date of service, whether or not the claim is pending, unless satisfactory arrangements have been made with our credit department.
4. Credit beyond $500.00 at 60 days from date of service is subject to approval by the credit department.
5. A finance charge of 1.5% per month (18% per annum) will be charged on all balances on our books over 90 days.
6. Budget plans are available through our credit department; payments may be scheduled over a maximum of twelve (12) months.
7. The parent or guardian who registers a minor child is ultimately responsible for the payment of the charges incurred at this facility regardless of circumstances involving divorce, custody, etc.
8. For your convenience, we bill Primary and Secondary Insurance; however, you are responsible for the payment of your balance in a timely fashion regardless of discrepancies and/or disputes with your insurance carrier.
9. Persistently delinquent accounts will be referred to an independent collection agency or small claims court, in which case you will assume the full responsibility for collection costs, including any attorney and/or court fees.

I have read and I understand the above credit policy and payment information.
(Parent or guardian must sign for minor children)

Signature_____ Date_____/_____/_____

PLEASE SELECT ONE OF THE FOLLOWING PAYMENT OPTIONS:

FOR THOSE WITH NO INSURANCE COVERAGE:

☐ 1. I would prefer to pay the balance in full on the date of service.

- ☐ Cash/Check
- ☐ Mastercard/VISA

☐ 2. Please send a bill for the balance over and above the $100.00 deposit. I will pay the balance in full within 30 days.

☐ 3. I would like to set up a schedule of monthly payments for the balance over and above the $100.00 deposit, not to exceed 12 months.

Signature_____ Date____/____/____

FOR THOSE WITH INSURANCE COVERAGE:

Please indicate your preference for payment of your copayment OR $50.00 - $100.00 deposit at the time of service:

- ☐ Cash/Check
- ☐ Mastercard/VISA/Discover
- ☐ Copayment $_____

My insurance pays at:_____%

My annual deductible is: $_____ per person

Has your annual deductible been met?

☐ Yes ☐ No ☐ Not Sure

My insurance will pay within 60 days from date of service. I understand I am responsible for any balance not covered by my insurance. I will take care of that balance by:

- ☐ Cash/Check or Mastercard/VISA at the time of service
- ☐ Bill me; I will pay in full within the first 30 days of my statement
- ☐ I will contact the Credit Department to arrange a payment schedule. 541-485-5652

☐ YES, my insurance requires either precertification or a referral for specialty services.

☐ NO, my insurance DOES NOT require either a precertification or referral for specialty services.

Signature_____ Date____/____/____