Allergy Affiliates

Linden David Ho, M.D., LLC

Payment Policy

Thank You for choosing the Allergy & Asthma Group. We are committed to providing you with quality and affordable healthcare. This policy is to help answer questions regarding patients and insurance responsibility for services rendered. Please read it, ask any questions you may have and sign the bottom. A copy will be provided to you upon request.

1. **Insurance**- We participate with most plans including Medicare. If you are insured with a plan we are not contracted with payment is expected at each visit. Please contact your insurance company with questions you have regarding your coverage.
2. **Copayments and deductibles**- all copays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **Non Covered Service**- Please be aware that some of the services you receive may be a non-covered service. You must pay for these services at the time of service or within the 30 day billing cycle.
4. **Proof of Insurance**- All patients must complete our patient registration form before seeing the doctor and provide a copy of their current insurance card.
5. **Claim submission**-We will submit your claims and assist you in any way we reasonably can to get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage Changes**-If your insurance changes it is your responsibility to notify us before your next visit so we can make the appropriate changes.
7. **Nonpayment**- If your account is over 90 days past due you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if your balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the practice.
8. **Missed Appointment**- Our policy is to charge a fee for a missed appointment not canceled within 24 hour of the appointment time. Please help us to serve you better by keeping your scheduled appointments.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**