SOUTHERN CALIFORNIA ALLERGY

ALLERGY | ASTHMA | IMMUNOLOGY

Office: 818-990-9155 | Fax: 818-990-9167
www.southerncaliforniaallergy.com

Financial Responsibility Policy

1. I understand that I, _____, am responsible for confirming my medical benefits or that of my dependent with my insurance group and that I am expected to have this information at the time of my visit.
2. I understand that Southern California Allergy cannot guarantee that the information received from my insurance company is accurate. I am fully responsible for all charges deemed my responsibility to my account.
3. I understand that Southern California Allergy will bill my insurance company according to all Federal rules and regulations regarding such activities and provides my insurance company with copies of all appropriate and required information and that Southern California Allergy is not responsible for lost claims.
4. I understand that Southern California Allergy will make any reasonable effort to assist me in resolving any disputed claims or payment for such claims, but that the contractual relationship for payment of such claims lies solely between myself and my insurance carrier and that I am ultimately responsible for all services provided.
5. I understand that if my plan is out-of-network or services are determined "non-covered" due to plan provisions and or preexisting conditions or riders on my policy, I am fully responsible for services incurred.
6. I understand that if I elect to pay privately at my first visit, due to lack of insurance, lack of coverage, failure to provide my insurance card at the time of service or failure to verify coverage, Southern California Allergy will not retroactively submit claim or change account responsibility.
7. I understand that it is my responsibility to provide accurate and updated insurance information to Southern California Allergy at every visit if applicable.
8. I understand it is my responsibility to proactively be involved in obtaining required referrals that may be required to obtain care depending on my insurance policy.

Assignment of Benefits

1. I understand and agree that I am responsible and must pay all deductibles, co-payments, and amounts disputed by my insurance carrier for healthcare services rendered by Southern California Allergy to me or my dependent.
2. I understand and agree that Southern California Allergy may utilize any legal means to collect payment for any healthcare services rendered to me or my dependent. In the event that legal action is taken, in order to enforce the terms and conditions of this agreement, the prevailing party shall be entitled to recovery of all attorney and or collection fees and costs.

No-show Fee/ Card-On- File Policy

For all appointments, we require a 24 hours' notice in the event of cancellation of appointments. If full notice is not provided, we will bill a $35 no show fee for medical appointments. Additionally, if you are more than 15 minutes late to your appointment and there isn't sufficient time to perform the appointment, the appointment may be cancelled or rescheduled.

Our policy is to have an active credit card on file to charge immediately for services, past due balances, payment plans, and no-show fees.

_____

Signature of receipt and acknowledgement of policies listed above

Date