Richmond Allergy and Asthma Specialists, P.C.

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FINANCIAL POLICY

It is the philosophy of Richmond Allergy & Asthma Specialists ("Provider") to work with and be fair with all patients when it comes to financial matters. To ensure that we maintain financial stability and can continue to provide medical services to the community and region, the following credit policies shall be enforced. If you have any questions or need for special consideration, please do not hesitate to call our business office.

Payment Responsibility: The patient is ultimately responsible for all charges incurred. For minor patients, **the parent bringing the minor child for the initial office visit for treatment will be considered the financially responsible party.**

Assignment of Benefits: The practice will bill insurance plans as a courtesy for our patients if the patient provides the required insurance information and signs an assignment of benefits statement. It is recommended that the patient also verify allergy benefits with the insurance company prior to coming in for the initial appointment.

Non-Covered Services: Payment for all charges which are not covered by insurance is due and payable at the time of service. This includes any deductibles, co pays and/or coinsurance, and durable goods. **No statements will be generated for patient balances less than $5.00. Patients are responsible for the balance on their account and the balance will be collected when the patient is in the office.**

Third Party Litigation: The practice will not become involved in disputes arising from third party claims (i.e., automobile accidents, liability claims, etc.) with the exception of *verified* Workers' Comp claims, or claims involving Medicare.

Uninsured Patients: When patients are not covered by insurance all incurred charges are due and payable at the time of service unless prior arrangements are made with the business office.

Payment Agreements: When a balance due cannot be paid at the time of service or when the balance becomes due, a payment agreement will be required in order to approve payment arrangements.

Payment Arrangements: If a patient is unable to make full payment of the patient balance when due, the balance due must be paid within 90 days of the service.

Payment Methods: The following payment methods will be accepted: Cash, personal checks, money orders, VISA, MasterCard or Discover.

Return Check Policy: Any returned check will incur a $35 fee that will be added to the account balance. After two returned checks, future payments must be made by cash, money order or credit card (Visa, Discover, or MasterCard).

Refunds: Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patient refunds will not be processed until all active or past due accounts are paid in full. **Refund of less than $5.00 will not be issued unless specifically requested.**

Delinquent or Bad Debt

Accounts: Patients with unpaid or delinquent accounts or accounts which have been transferred to collections may be denied treatment for non-emergency services. Services provided will be on a ***cash only*** basis.

Referral for Collections:

Accounts that cannot be collected by the business office after normal in-house collection procedures may be referred to a collection agency, magistrate or attorney for further collection action.

By my signature below and, in the event an account is turned over to collections, I agree that:

- Provider is authorized to release all information, employment or otherwise, to its collection agency, or its attorney.
- Balances older than 90 days are past due may incur an 18% annual percentage rate (APR) finance charge (1.50% per month).
- If any debt owed to the Provider is referred to an attorney or collection agency for collections, I agree to pay all attorney and collection fees in the amount of thirty-five percent (35%) of the total indebtedness, including all court costs and filing fees incurred by the Provider whether or not suit is filed. I understand and agree that if the Provider obtains judgment relating to this agreement or any debt incurred thereof, I will pay judgment interest of one and one-half percent (1-1/2%) per month or eighteen percent (18%) per annum, beginning on the date of judgment. I also agree that Henrico, Virginia shall be the proper venue for any action brought pursuant to this agreement. I further understand and agree that a photocopy of this contract shall be considered as valid as the original.
- the Provider and its agents are authorized to contact me by telephone or text message at any phone number associated with my account, including wireless telephone numbers, which could result in charges to me. I also authorize the Provider and its agents to contact me via email. I further authorize the Provider and its agents to contact me using any method of contact available including but not limited to using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

Please note in signing and dating below, you are acknowledging that you have read, understand, and agree to the terms of the above Financial Policy for Richmond Allergy & Asthma Specialists.

Signature: _____ **Date:** _____

Print Name: _____ **MR#:** _____

(office use only)