FINANCIAL POLICY

This policy ensures patients understand their financial responsibilities and our office's billing practices. We are committed to providing high-quality medical care and helping you understand your financial responsibilities. Please read this document carefully and ask our team if you have any questions.

1. Insurance Verification & Authorization

Your health insurance plan is a contract between you, your employer, and your insurance company. We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means we will bill those plans for which we have an agreement and will require you to pay only the authorized copayment, deductible, or coinsurance at the time of service.

It is the patient's responsibility to confirm that we are a participating provider with their plan. We will verify your benefits and submit claims as a courtesy; however, this does not waive our right to seek payment directly from you for services rendered. All insurance benefit quotes are estimates and not a guarantee of coverage.

- **Proof of Insurance:** You must provide a valid, current insurance card and government-issued photo ID at every visit and notify us of any changes to insurance.
- **Authorization to Release & Process:** I hereby authorize Los Angeles Food Allergy Institute/AllergyDox its authorized representatives to:
    1. Release any medical information necessary to process claims or obtain payment
    2. Process insurance claims and accept benefits for services provided
    3. Access insurance eligibility information from my plan
    4. Allow a photocopy of my signature to be used to process insurance claims.

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

- **Referrals:** If your insurance requires a referral or prior authorization, it is your responsibility to obtain it before your visit. Services provided without the required referral or authorization will be your financial responsibility.

2. Patient Financial Responsibility

- **Office visits:** If your office visit applies towards your unmet deductible of $100 or more, then a deposit of $100 will be collected in addition to any co-payment responsibility.
- **Co-pays & Deductibles:** All co-payments, deductibles, and co-insurance amounts are due at the time of service for all other services.
- **Self-Pay:** Patients without insurance or those choosing not to use their insurance must pay in full at the time of service.

3. Non-Covered and Denied Services

Some services may not be covered by your insurance. We will bill your insurance first; however, if they deny payment, payment will become your responsibility. Common reasons for denial include:

- i. Experimental, investigational, or cosmetic services under your plan's rules.
- ii. Exceeding visit, frequency, or quantity limits.
- iii. Not medically necessary under your plan's rules.
- iv. Excluded from your benefits.

We will provide an Advance Beneficiary Notice (ABN) for any non-covered services.

Appeals: You may appeal insurance denials directly with your insurer. We will provide supporting documentation upon request.

Dual Commercial and Medicaid insurances - Our practice does not accept patients who are concurrently enrolled in both a commercial insurance plan (HMO or PPO) and a Medicaid plan. Patients are responsible for disclosing all active insurance coverage at the time of scheduling, registration, and throughout the course of care. If it is determined at any time that a patient has concurrent commercial and Medicaid coverage, the practice may refuse or discontinue services.

4. Minors, Divorce, and Separation

- **Minors:** A parent or legal guardian must accompany patients who are minors (under 18 years of age). The accompanying adult is responsible for payment of the account at the time of service, according to the policy outlined in this document.
- **Divorce/Separation:** In divorce or separation cases, the parent with whom the child resides will be listed as the guarantor of the account and is therefore responsible for any balance incurred.
    - If a divorce decree requires the non-custodial parent to pay all or part of medical expenses, it is the custodial parent's responsibility to seek reimbursement from the non-custodial parent. We do not handle financial disputes between parents.

5. Administrative Fees (Forms, Letters & Medical Records)

- **Completed Forms (e.g school):**
    - 2 week turnaround: $60 dollars clerical cost and $5 dollars per page
    - 72 hour turnaround: $110 dollars clerical cost and $5 dollars per page

- **Letters:**
    - 2 week turnaround: $100 dollars clerical cost and $5 dollar per page
    - 72 hour turnaround: $200 dollars clerical cost and $5 dollar per page

- **Medical Records:** Lab results can be faxed or emailed free of charge. If printed or mailed and for all other medical records, please see below:

    Printed:

    - 2 week turnaround: $25 clerical cost and $0.25 per page
    - 72 hour turnaround: $40 clerical cost and $0.25 per page
    - If records are to be mailed then $10 dollars is added for 1st class USPS mail

- **Emailed/Faxed Medical records:**
    - 2 week turnaround: $15 clerical cost only
    - 72 hour turnaround: $30 clerical cost only

6. Refunds, Disputes & Outcomes

- **No Refunds on Outcomes**: Payment is for professional services rendered, not for outcomes. No refunds or rebates will be issued regardless of clinical results or patient satisfaction.
- **Chargebacks:** You agree not to dispute or request a chargeback for valid charges. Doing so may result in administrative fees and dismissal from the practice. We encourage patients to contact our billing team first to resolve any concerns.

7. Credit Card on File (CCOF)

To streamline billing, we require a valid credit card on file. Your card will be charged for balances (such as deductibles or non-covered services) after your insurance has processed your claim.

- **Security:** Card numbers are encrypted and stored securely off-site; no full card numbers are stored at our practice.

8. Cancellation & No-Show Policy

We reserve a significant amount of time for your appointment. Missed appointments prevent us from treating other patients.

- **Notification:** We require at least 24 hours' to cancel or reschedule.
- **Fees:**
    - **New Patient Missed Appointment:** $150
    - **Established Patient Missed Appointment:** $150
    - **Procedure/Testing Missed Appointment:** $250
    - **Allergy shots:** $5
- These fees are not covered by insurance and will be charged to the card on file.

Acknowledgment & Signature

- I acknowledge that I have read and understand this Financial Policy. A copy will be provided to me upon request.
- I understand this agreement will remain in effect until I have formally revoked it in writing.
- I understand this financial policy may be amended without prior notice.
- I am fully aware that having health insurance does not absolve my responsibility to ensure that my bills for professional services are paid in full. I understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Patient Signature:_____

Printed Name: _____ (Patient, Relative or Guardian)

Relationship to patient (if applicable):_____

Date and Time: _____

Witness Signature:_____(Required if not signed by patient)

Printed Name:_____Date and Time:_____

Interpreter (if used): _____ Date: _____