CONSULTANTS IN
ALLERGY & ASTHMA CARE

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Office Policies and Procedures

Thank you for choosing Consultants in Allergy & Asthma Care, LLC for your healthcare needs. Please review the following policies.

Financial Policy

Your healthcare insurance information is required when making an appointment. Although we check insurance eligibility**, it is the patient's - or the guarantor's - responsibility to check benefits, eligibility, and insurance plan network participation (in or out-of-network) with your insurance carrier before your appointment**. If applicable, we will bill your insurance carrier. However, patients are responsible to pay for any services considered **non-covered** by your insurance carrier.

If you have **HMO** or **POS** coverage through your health insurance company and you are required to have a written referral in order to be evaluated by us, you **must confirm with us that our office received it before the appointment.**

Your health insurance company may require a co-payment at the time of your appointment. You are **required to pay any co-payment at the time of the office visit -** according to the terms of your health insurance coverage and our contractual obligation with the insurance companies.

Self-pay patients are responsible for all charges, and payment is due in full at the time of service unless other payment arrangements have been previously made.

We understand that financial difficulties may occur. No business can operate and pay its expenses, though, if its clients have an infinite amount of time to pay their balances. Please call our billing office at 847-579-4265 to arrange a payment plan.

Outstanding balances over 90 days may be transferred to a collection agency and may be cause for patient dismissal from the practice.

Forms or correspondence that requires more than 30 minutes to complete will be completed for an **administrative fee of $30**. We hope that you understand the amount of time and cost associated with the completion of these requests.

If you are requesting a copy of **medical records** for **your personal file,** there will be a **$20 fee** for records with 20 pages or more. We ask that you fill out our authorization to release medical records form.

No Show/Missed Appointment Policy

We pride ourselves in providing individualized health care for our patients. Although we realize that emergencies happen, please keep in mind that our doctor **does not double-book** appointments. Therefore, we require that you contact our office at least 24 hours before your scheduled appointment if you need to cancel or reschedule.

If less than 24-hour cancellation notice is given, the appointment will be documented as a "Missed" appointment. If you **do not come for your appointment and no notice is given**, this will be documented as a "No Show" appointment. Please be advised that these may result in a **$30 cancellation fee.**

Saturday appointments are, however, highly demanded and we have limited **new patient and testing appointment** slots. Therefore, we **require a credit card when booking a new patient or testing appointment for Saturdays**. A 24-hour cancellation notice is required. If a No Show/Missed appointment occurs, our office **will charge a $50 cancellation fee to the card**.

Prescription Refill Policy

Prescription refills require monitoring of the patient by our doctor to ensure that the prescribed medication can be continued safely and effectively at the appropriate dose and frequency.

An annual office visit is required for all of our patients who receive prescription medication.

If you have not been seen in over 12 months, an appointment will be necessary before any further refill is provided. Failure to keep your appointments may be a cause to discontinue the physician-patient relationship.

If you have not received face-to-face professional services by our doctor in over 3 years, **no refill will be provided.** The general rule in health care outpatient practices is that if you have not seen a doctor face-to-face within **36 months, you are considered to be a new patient** and would need to reestablish care.

We appreciate your cooperation in this matter and please let us know if you have any questions or need a copy of this document.

I have read, understand, and agree to the above office policies and procedures.

_____	_____	_____
Patient Name	Date of Birth	Date

_____	_____
Patient Signature or Parent/Guardian (if minor)	Relationship to the Patient