ALLERGY & ASTHMA CONSULTANTS OF ROCKLAND & BERGEN

LOURDES B. de ASIS, MD, MPH, FACP, FAAAAI
SHARON YEE, MD, MS

PATIENT DEMOGRAPHIC INFORMATION

Last Name _____ **First Name** _____ **MI**____

Address _____

City _____ **State** _____ **Zip Code** _____

Birth Date _____ **Social Security Number** _____

Birth Sex: _____ **Pronouns:** _____

Race: White ☐ Asian ☐ Black/African Amr ☐ Native Am/Alaskan ☐ Native Hawaiian/Pacific Islnd ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Dominican ☐ Decline to Specify ☐

Language: _____ **Reminders:** Text ☐ Call ☐

Marital Status: _____ **Language:** _____

Home Phone#: _____ **Cell Phone#:** _____

Email Address: _____

Occupation: _____ **Work Phone#:** _____

Referring Dr: _____ **Primary Care Dr:** _____

Emergency Contact Name: _____ **Relation:** _____

Emergency Contact Phone#: _____

INSURANCE INFORMATION

Primary	Secondary
Insurance Company:	
ID #:	
Group #:	
Start Date:	
Policy Holder's Name	
Relation to Policy Holder:	
Policy Holders Address:	
Policy Holder's Relationship to Patient:	
Policy Holder's D.O.B.	
Policy Holder's SSN:	
Policy Holder's Phone:	

I hereby authorize release of any information required to process insurance claims related to services rendered by this office.

Signature: _____ **Date:** _____

PATIENT INSURANCE WAIVER

I, _____, have requested treatment from the Allergy & Asthma Consultants. I agree that I am responsible for all charges incurred for any visit. I understand I will be responsible for payment <u>if</u>:

- I am not insured with a participating insurance plan
- There are any fees due to an uncovered/not yet reached deductible
- I do not provide the necessary insurance referral from my PCP on the day of my visit, if required by my insurance plan
- I do not provide the correct insurance information to the office
- My insurance plan has been canceled
- My insurance does not cover the services rendered
- I don't comply with my insurance company request for information (i.e., full time student status, other insurance information)

I am aware that some insurance companies might not cover certain procedures and, in such instance, I will be responsible for the charge associated with the non-covered service. I hereby authorize payment for all medical benefits directly to Allergy & Asthma Consultants of Rockland & Bergen P.C. (P.A.).

Patient Signature_____ DATE_____

<u>Authorization of Payment by Credit Card</u>

PLEASE NOTE: A credit card is required on file for all patients with a deductible as a security precaution. You may choose an alternate form of payment at the time payment is due.

- ☐ Visa: Account # _____ Security Code _____
- ☐ Mastercard: Account # _____ Security Code _____
- ☐ American Express # _____ Security Code _____

  Exp. Date: _____ Signature: _____

AUTOPAY ELECTION – Save time, postage and paper! ☐

I hereby elect to authorize payment of my deductibles, co-insurance and/or copayment balances to be automatically debited from my account when necessary.

Payment Policy

Thank you for choosing Allergy and Asthma Consultants of Rockland & Bergen (AACRB). We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.
Our goal is to provide you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, please ask to speak with one of our billing specialists to discuss other payment options. If you are insured by a plan we participate with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims 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, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 30 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or by notifying us at least 24 hours prior to your appointment if you need to reschedule.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist.

How May I Pay?
We accept payment by cash, check, and all major credit cards.

Do I Need A Referral or Pre-certification?
If your insurance plan requires a referral authorization from your primary care physician or a pre-certification from your insurance, you need to contact your primary care physician or insurance company to be sure it has been obtained. If we have not received an authorization prior to your arrival at the office your appointment will be rescheduled.

Which Plans Do You Contract With?
AACRB accepts most major insurance plans. Please ask our front desk for a list of plans we participate with. It is always best for you to contact your insurance company prior to your appointment to confirm that we participate with your specific insurance plan.

What Is My Financial Responsibility for Services?
It is your responsibility to provide us with accurate information to enable us to process your claim correctly, which includes up-to-date personal information regarding ALL applicable insurances.
It is your responsibility to verify that the physicians and/or facility in which you are seeking treatment are an authorized provider under your insurance plan. A current provider listing should be made available to you by your employer, insurance company or insurance company's web-site.
Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our practice by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. Do not assume that you will not owe anything if you have more than one insurance policy.

What If I Have Billing or Insurance Questions?
AACRB is supported by a staff of dedicated professionals. Our office staff has the expertise to assist in all financial matters, relieving the patient of burdensome paperwork.

Your financial responsibility depends on a variety of factors, explained below:

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all deductibles, office visits, allergy testing, injections, desensitization, and other charges at the time of office visit.	Accept your initial payment and file an insurance claim as a courtesy to you. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any deductibles and unpaid balances by your plan.
HMO & PPO plans with which we participate	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Accept your initial payment and file an insurance claim as a courtesy to you.
HMO with which we do not participate.	Payment in full for office visits, testing, desensitization, injections, and other charges at the time of office visit.	Accept your payment in full and file an insurance claim as a courtesy to you.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Accept your initial payment and file an insurance claim as a courtesy to you.
Medicare	If you have Regular Medicare, and have not met your deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit after your Medicare deductible has been met. If you have Regular Medicare as primary, but no secondary insurance:	Accept your Medicare deductible (if applicable) and file the claim on your behalf, as well as any claims to your secondary insurance.

If You Have...	You Are Responsible For...	Our Staff Will...
	Payment of your 20% copay is requested at the time of the visit.	
Medicare HMO	All applicable copays and deductibles at the time of the office visit.	Accept your initial payment and file an insurance claim as a courtesy to you.

Testing/ Desensitization

If your physician recommends extensive allergy testing and/or desensitization, this will be scheduled by our nursing coordinator. She will answer specific questions about the procedure, scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Billing Department will require a deposit in the amount of $500.00 to go towards your co-payment, deductible or any other amount deemed the patient's responsibility by your insurance carrier. After your insurance company has processed your claim, any amount remaining as a credit balance will be refunded to you.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors (under 18) on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

What if I missed my appointment to see the Physician?

We understand that on rare occasions, issues may arise causing you to miss your appointment without the ability to notify our office prior to your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours before your appointment to have it rescheduled.

Our highly skilled Physicians are committed to your wellbeing and have reserved time just for you. Patients that miss more than one appointment, without notifying our office 24 hours prior to the scheduled appointment, are subject to a $50.00 missed appointment fee.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above Payment Policy and agree to abide by its guidelines. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service, are my responsibility.

I authorize Allergy and Asthma Consultants of Rockland & Bergen to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Allergy and Asthma Consultants of Rockland & Bergen.

_____ _____

Signature Date

_____

Printed Name