Premier
ALLERGY, ASTHMA & SINUS CARE
John G. Latall, MD Board Certified Allergy and Immunology
Lincoln Park • Loop • Niles
T 773.665.4016 • F 773.360.6200

Patient Financial Policy

Thank you for choosing us as your healthcare provider. The following information is to familiarize you with our billing policies. Please read the following information carefully. Let us know if you have questions regarding this policy prior to receiving services.

- Full payment for professional services is due at time of service. As a courtesy to our patients, PAASC will bill your insurance company. Any co-pays are due at the time of service and prior to treatment.
- Your insurance is a contract between you and your insurance company. We are not a party to that contract. Co-pays are a contractual obligation that you agreed to when you signed with your insurance company. A co-pay is the patient's shared financial responsibility for payment for office visits. As such, if your policy shows you have a co-pay, we are obligated to collect that co-pay on behalf of your insurance company.
- For any appointment with a provider (MD or physician assistant), balances must be paid in full prior to being seen for your appointment. This includes new vial visits and follow-ups.
- Upon receipt of payment from your insurance company, you will receive a statement showing your balance due.
- Statements are sent to patients via email only, unless other arrangements are made. Please make sure that your email address is correct in our system by verifying with one of our staff members.
- We require that all patients have a credit card on file as payment method for the portion of services that your insurance doesn't cover and which you are liable for. If payment is not received within 30 days of the statement date, we will charge the remaining balance to your credit card on file. Your card will be kept in our PCI compliant, secured database. A non-refundable $50 fee will be charged if the card declines; this is an additional fee that will not apply to your balance. For your convenience, we accept Visa, MasterCard, Discover, and AmEx. If you wish to give a different method of payment than the card on file, please call our billing team at 773-665-4016 before 30 days from statement date.
- You may opt to leave a $500 deposit in lieu of leaving a credit card on file. If your deductible is more than $500, you will be required to put that full amount down as a deposit.
- You are responsible for making sure that any payments made via a third party (i.e. Chase bill pay, InstaMed) are being credited to your patient account. You may call our office at any time (773-665-4016) to verify these payments with our billing team.
- You must inform our office if you have a new insurance carrier or any changes to your insurance. Any payment that is denied due to failure to notify us will be the patient's responsibility.
- In the event your bill is not paid after 90 days, it will be turned over to our professional collection agency, American Profit Recovery. Information given to them may include, but is not limited to, your name, address, phone number, and employment info. The collection vendor may report your delinquency to a credit bureau and may file litigation in efforts to collect the total balance due. Any litigation fees will be applied to the collection balance. If your account is turned over to collection due to non-payment, you will be charged a $100 administrative fee.

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- HMO patients are responsible for obtaining the necessary referrals for office visits and services prior to your appointment. If no referral is presented, you will be considered self pay and payment is due prior to your visit.
- It is your responsibility to know your healthcare plan benefits and be prepared to pay for non-covered services, co-pays, deductibles, and co-insurance. Patient will be responsible for any charges not paid for by insurance within 45 days. It is the patient's responsibility to contact their insurance company for any disputes.
- It is your responsibility to know if your insurance provider requires you to use a specific company or facility for laboratory, radiology and/or any outside services ordered by our practitioners. HealthLab is a laboratory company that provides phlebotomist services in our facility during our clinic hours. These services are not owned or managed by PAAS, and therefore we cannot verify or guarantee if HealthLab services are covered by your insurance provider or plan.
- You are advised that this office charges a fee for any forms completed on a patient's behalf. This includes, but is not limited to, school forms, disability forms, FMLA forms, work forms, etc. The fee starts at $25 and increases based on the amount of provider work required.
- There will be a $100 fee for any appointment that is missed or canceled less than 24 business hours in advance. Excessive cancellations or missed appointments may result in additional fees or dismissal from the practice. If you receive a 'missed' fee of $100 for missing or not canceling/rescheduling your appointment without 24 business hours' notice, this charge will automatically be charged to your credit card on file.
- Any past due balances must be paid in full prior to any service being rendered or appointment made.
- This office reserves the right to changes its fees at any time without prior notice.

AUTHORIZATION OF ASSIGNMENT OF BENEFIT

I have read, understand and agree to the above financial policy (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information; I certify this information is true and correct to the best of my knowledge. I will notify PAASC of any changes in my health status or any of my information including but not limited to insurance, address, and phone numbers.
I hereby authorize my insurance benefits be paid directly to Premier Allergy, Asthma & Sinus Care and I am responsible for non- covered services.

Patient Name: _____ DOB: _____ Date: _____

Patient Signature (or Guardian Signature, print name and relationship):

_____

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Credit Card Authorization Form for Credit Card on File

At Premier Allergy, Asthma & Sinus Care, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover and which you're liable for.

Rest assured, we keep your credit card information confidential and secure via our PCI compliant credit card processor, Tidal Pay. Office personnel will not have access to your card once it is saved to the secure account. For your protection, only the last 4 digits of your card will show in the system. Also, we will make a charge to your card only after we have filed the claim and your insurer has processed it. This means that the insurance portion of the claim gets paid, adjustments made and posted to your account first, and then any remaining amount is charged to your card on file unless payment has already been made.

I authorize Premier Allergy, Asthma & Sinus Care to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **AmEx**

Last 4 Digits of Credit Card Number: XXXX-XXXX-XXXX-_____

Expiration Date: _____ / _____ / _____

Cardholder Name: _____

Signature: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

I, the undersigned, authorize Premier Allergy, Asthma & Sinus Care to charge the portion of my bill that is my financial responsibility as per the insurance company EOB to the following credit card. If you receive a 'missed' fee of $100 for missing or not canceling/rescheduling your appointment without 24 business hours' notice, this charge will automatically be charged to your credit card on file.

I understand that my credit card will be charged 30 days after statement date if other arrangements have not been made. I will receive a receipt via email only. I agree to notify and update my credit card as necessary. A $50 fee will be added to my account if my credit card declines.

This authorization relates to all payments not covered by my insurance company for services provided to me by Premier Allergy, Asthma & Sinus Care.

This authorization will remain in effect until I (we) cancel it. To cancel, I (we) must give a 60-day notification in writing to Premier Allergy, Asthma & Sinus Care, and the account must be in good standing.

Patient Name (Print): _____

Patient (or Guardian) Signature: _____
Date: _____ / _____ / _____