ALLERGY & CLINCAL IMMUNOLOGY MEDICAL GROUP

BERNARD D. GELLER, M.D., Ph.D.
SANDRA HO, M.D.

FINANCIAL POLICY

Thank you for selecting our office for your medical care. Although our main concern is to give the proper and optimal care and treatments to restore your health, *please read the following financial policy to avoid any misunderstandings.*

_____ **The patient or guarantor is responsible for payment *at the time of service*.** This means that co-pay's and balances must be paid when the patient is seen.
(Initial)

PPO or Contracted Insurance Coverage

If you have coverage through an insurance company with whom we have a contract, we require ***a copy of your insurance card* and *driver's license*** *(or other identification)*, ***your mailing address and payment of your co-pay, coinsurance or deductible at the time of service***. If you, or the patient, later be determined ineligible for the services rendered, you agree to comply with the demands for payment from the provider. Charges may apply for telephone consultations. Payment is due upon receipt of your statement.

Cancellation Policy

_____ ***All appointments must be cancelled with at least 24 hours notice or you will be charged.***
(Initial)

Laboratory Services

We may draw blood to be sent to an outside lab for processing. Depending on your insurance, you may receive a separate bill from the lab (you may be able to submit a claim to your insurance company if the lab has not already done so for you). Some insurance companies require you to use a specific lab or hospital for your lab tests. ***Because there are over 1,000 insurance companies, we cannot keep up with the constantly changing rules for each one.*** For this reason, we expect you to be familiar with your own insurance companies' requirements, and, if for any reason they do not allow you to use the lab we contract with, it is your responsibility to make us aware of this. You may choose to pay for your own lab tests or go to the laboratory where your insurance requires you to go.

I have read the above information and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for services rendered.
In the event that my insurance is billed, I authorize payment of medical benefits to be paid directly to Allergy & Clinical Immunology Medical Group or Bernard D. Geller, M.D. I authorize the release of any medical information necessary to process my claims. A fax or photocopy of this agreement shall be considered as effective as the original.

Disclosed non-covered medical services are the responsibility of the patient.

Patient Name_____
(Print)

Responsible party (if other than patient)_____
(Print)

Signature of responsible party_____ **Date**_____
(Sign)