

Welcome To Our Practice☺

Thank you for choosing Northern Arizona Allergy, Asthma & Immunology to partner in your healthcare needs. We are committed to providing you with quality healthcare. Below are our office and financial policies. Please take a moment to read this in its entirety. If you require additional clarification, or have questions about any of the policies, please contact our office and we will be happy to assist you.

OFFICE POLICIES

- **Referrals/Authorizations:** Referrals/authorizations from your Primary Care Physician (PCP) or Insurance Company approving visits to our office, diagnostic testing, or labs can take several days to retrieve. **IT IS YOUR RESPONSIBILITY TO NOTIFY YOUR PCP AT LEAST 2-WEEKS PRIOR TO YOUR APPOINTMENT TO MAKE SURE A REFERRAL/PRIOR AUTHORIZATION HAS BEEN APPROVED.** The referral/authorization must be sent to our office prior to your appointment. Failure to do so will result in your referral/authorization being denied by your PCP or insurance company; therefore the patient/guardian will be responsible for any and all charges incurred during your visit.
- **PHONES:** Telephones are answered Monday thru Friday 8:00 am to 4:00 pm. There are exceptions to this policy, however adjusted hours will be posted.
- **EMERGENCIES:** If a problem arises during a time when the office is closed, simply call the office at (928) 774-1700 and the answering service will contact the doctor on call. Your call will be returned in a timely manner. **PLEASE NOTE THAT ROUTINE PRESCRIPTION REFILLS, SCHEDULING AND BILLING QUESTIONS ARE NOT CONSIDERED EMERGENCIES AND WILL NOT BE DONE AFTER HOURS.**
- **PRESCRIPTIONS:** All prescription refill requests should be called in to your pharmacy. Your pharmacy will then contact our office if authorization is needed. **Your refill requests will be reviewed and processed within 48-hours of request.** Please notify the office ONLY if you are requesting your medications be called into a new/different pharmacy.
- **TEST RESULTS:** Please allow 7-14 days for test results. All results must be reviewed by the provider once they are available. These results will be discussed at the next office visit.
- **RECORDS RELEASE:** It takes our office 7-business days to process medical record requests. If records are stored off-site we require 14-business days to process. Medical records will be released to any physician upon your written request as a courtesy. **There is a fee of \$0.25 per page for “non-treatment” medical record releases which is required upon release of the medical records.**
- **FORMS COMPLETION:** Completion of forms for insurance purposes, such as application for insurance coverage, disability or FMLA leave, will be billed to the patient, or representative that requests completion of the forms. There is a \$25.00 fee for these services.

INSURANCE AND PAYMENT POLICIES

- **PROOF OF INSURANCE: YOU MUST PRESENT YOUR INSURANCE CARD TO US AT EVERY VISIT.**
If you fail to provide us with the correct insurance information at each visit, you may be responsible for payment for all services provided.
 - ❖ Your health insurance contract is between you and your insurance company. Knowing your insurance benefits is your responsibility. Any questions or complaints regarding your coverage should be directed to your insurance company.
 - ❖ We are contracted with most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at the time of service.
 - ❖ If you are insured by a plan we are contracted with, however do not provide us with an up-to-date insurance card, **payment in full is required until we can verify your coverage.**
 - ❖ If you are uninsured please contact our office to obtain an estimated quote for impending services.
 - ❖ **If your health plan has changed, you are responsible for notifying us as soon as possible.** If we are not aware of the changes, you could be held liable for the full cost of your visit. There are submission limitations and specific timelines for claims to be submitted. If you do not provide us the new information you will be responsible for all charges.

- **CO-PAYMENTS/DEDUCTIBLES:** Your insurance company requires us to collect co-payments and/or deductibles **at time of service.** Waiver of co-payments and/or deductibles may constitute fraud under state and federal law and/or the contract terms of your insurance company.

- **NON-COVERED SERVICES:** Please be aware that some or all of the services you receive may be a non-covered benefit or not medically necessary by your insurance company. You will be responsible to pay for these services in full.

- **CLAIMS SUBMISSION:** We will submit your claims as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance may need you to supply information directly to get your claims paid. If you fail to comply with their request you will be responsible for all charges.

- **ACCOUNT BALANCES:** Account balances are to be paid in full unless acceptable payment arrangements have been established with the billing office.
 - ❖ Unpaid account balances over 90-days will be referred to a collection agency for resolution.

- **DUAL CUSTODY OF CHILDREN:** In cases where parents have dual custody over a minor child, or where there is a legal document assigning rights to one parent, our policy is to assign financial responsibility to the parent who **AUTHORIZES** treatment for the child. This authorizing parent is responsible for paying the guarantor's share of the treatment costs. If you are in this situation, and there is a legal document assigning financial responsibility to another party, it is your responsibility to make payment arrangements with the other party prior to the child's appointment, to ensure that payment is received for treatment.

- **RETURNED CHECK FEE:** There is a \$35.00 returned check fee that will be assessed for checks that are returned to us by your financial institution for insufficient funds.
- **MISSED APPOINTMENTS/CANCELLATIONS:** There is a \$25.00 missed appointment fee that is assessed for appointments not cancelled or rescheduled with a minimum of 24-hours prior to the appointment. The fee will be your responsibility and billed directly to you.
- **NO SHOWS/NO CALLS:** If you do not show up for a scheduled appointment and make no attempt to call we will not reschedule your appointment.
- **EXISTING PATIENTS WHO RECEIVE CARE THROUGH OUR OFFICE MUST BE SEEN FOR FOLLOW-UP WITHIN 1-YEAR SINCE LAST DATE OF SERVICE IN ORDER TO CONTINUE THERAPY SUCH AS PRESCRIPTION REFILLS AND DOCTOR ADVICE INCLUDING THERAPY CHANGES AND TREATMENTS.**

Thank you for reviewing our policies. Please let us know if you have any questions.

Cut at dotted line and place in chart

I have read and understand the office policies and insurance/payment policies. I agree to abide by their guidelines.

Patient Name: _____

Date: _____

Signature of Patient/Parent/Guardian