Daher Asthma and Allergy Clinic PLLC

2136 Exeter Rd, Ste 103

Germantown TN 38138

PATIENT FINANCIAL POLICY

Updated as of October 22, 2020

Insured Patients

As your medical provider, our relationship is with you, not your insurance company. As a courtesy, we will file your insurance claim for you. However, if your insurance company does not respond or pay the claim within sixty (60) days, you will be expected to follow-up with your insurance company. You are responsible for any amount your insurance does not pay. If you are uncertain about your health insurance policy benefits, you should contact your health plan to learn the details about your benefits, out-of-pocket expenses, and coverage limits.

All co-payments, deductibles, coinsurance, and any outstanding balance from previous visits are due in full at the time of service. You will be billed for any additional amounts due after your insurance company pays its portion of the charges. If your company requires pre-certification/pre-authorization prior to your services, it is your responsibility to ensure that the insurance company's requirements are met prior to services being performed. If your insurance company denies charges due to a failure to meet pre-certification/pre-authorization requirements, you will be responsible for the denied charges. If you inform us of the precertification/pre-authorization requirements prior to receiving services, we will gladly assist you in obtaining pre-certification/pre-authorization.

You must inform us of any changes regarding your insurance and provide us with new insurance card. You must also inform us of any address change, name change, or other change which may affect your insurance billing.

Uninsured or Self-Pay Patients

A minimum deposit of $200.00 or the actual charges, whichever is less, is due at the time of service for all self-pay patients. If the actual charges exceed $200.00 and you cannot pay in full at the time of service, you will need to speak with the billing office to set up a three-month payment plan.

If you have insurance but are choosing to exercise your HIPAA right to pay out of pocket, you must complete the HIPAA Restriction Request Form and pay all charges in full at the time of service.

Methods of Payment

For your convenience, we accept: 1) Cash 2) Check 3) Mastercard, Visa, Discover, Care Credit and

American Express credit cards. A fee of $30.00 will be charged for all returned checks.

Collections

If you do not make payments to your account and you do not contact our office to make financial arrangements, your account may be assigned to a collection agency after sixty (60) days of no payment on the account.

If your account is placed with an outside collection agency, your balance will need to be paid in full with the collection agency before you may receive services from our clinic. We reserve the right to dismiss you as a patient from our clinic due to unpaid bills.

In the event that your account is placed with a collection agency, a collection fee of up to 33 and 1/3% may be added to your account and shall become a part of the total amount due. You will be responsible for any and all collection fees, attorney's fees and court costs.

Cost of Form Completion

Due to the time and complexity of completing various forms, such as Family Medical Leave Act (FMLA) and School Forms, and letters for Disability Applications you may need to pay a fee (not to exceed $40.00) for the completion of such paperwork. You will be informed of the cost and the amount must be paid prior to the completion of the paperwork.

Services for Minors

For all services rendered to a minor patient (under age 18), the adult accompanying the minor patient is responsible for the payment of the charges, unless other arrangements have been made in advance with the billing office.

Assignment of Benefits and Responsibility to Pay

I hereby assign all medical benefits to which I am entitled and authorize and direct my insurance to issue payment directly to Daher Asthma and Allergy Clinic, PLLC for medical services to myself and /or my dependents. I have read and understood this financial policy and I agree to be bound by its terms. Any questions I had were answered to my satisfaction. These are the terms and conditions that will apply to the patient's visits until such time as the policy is updated again and the clinic reserves the right to update the policy from time to time.

_____________________________________ ____

Print Name of Patient Signature of Patient (or responsible party)

____________________________________ ____

Print Name of Responsible Party Relationship to Patient

____________________________________ Date ____